S. HRG. 98-851

MEDICARE: PRESENT PROBLEMS—FUTURE OPTIONS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

WICHITA, KS

APRIL 20, 1984

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1984

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, DC 20402

35-400 O

S141-12

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MEDICARE: PRESENT PROBLEMS—FUTURE OPTIONS

FRIDAY, APRIL 20, 1984

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Wichita, KS.

The committee met, pursuant to notice, at 9 a.m., in the city commission chambers, Wichita, KS, Hon. Nancy Landon Kassebaum presiding.

Present: Senator Kassebaum.

OPENING STATEMENT BY SENATOR NANCY LANDON KASSEBAUM

Senator KASSEBAUM. The hearing will please come to order. It's a pleasure to welcome everyone this morning with the dire weather forecasts that are here. And I am particularly pleased to welcome the witnesses who agreed to serve this morning in the official hearing of the Special Committee on Aging called "Medicare: Present Problems and Future Options."

Traveling throughout Kansas, I consistently have found health-related issues to rank at the top of the list of concerns expressed by not only older Kansans, but also younger people. This has been the case for the past several years.

I am pleased to have the opportunity to chair this hearing this morning as part of an ongoing effort to oversee the operation of medicare and to examine the various proposals that have been made for its future.

Since its enactment in 1965, medicare has offered a sense of security to individuals who recognize that the aging process inevitably takes its toll in the form of higher medical bills. This sense of security is being steadily eroded as the elderly see reports of the declining financial status of the medicare trust fund and persistent health cost inflation.

It has become clear that Congress in coming years will be asked to address these serious concerns. Earlier this month, the medicare board of trustees issued its annual report on the financial status of the system. This report indicates that, using intermediate economic assumptions, the trust fund which supports medicare hospital, or part A, benefits will be depleted by 1991 if corrective action is not taken. Even under the most optimistic economic assumptions, problems with the trust fund will occur by 1995.

On a more optimistic note, the medicare trustees indicate that the initial steps we have taken, notably the initiation of prospective payment for hospitals, will work to reduce the long range defi-

cit of the trust fund. They do, however, recommend that Congress consider further action.

Although the financial status of the hospital insurance portion of medicare is of most immediate concern, interest has been mounting in restraining the growth of supplementary medical insurance, or part B, benefits. This portion of the program is financed through a combination of premiums and general revenues and is actuarially sound. However, there is a great deal of concern about the rapid growth of this portion of the program, which is increasing at an annual rate of 16 percent.

The congressional response to this situation will undoubtedly mean some revisions in the medicare program itself. Yet, it is shortsighted to believe that a response confined only to medicare will be either equitable or effective. Of the projected 13.2 percent increase in hospital costs attributable to medicare, only 2.2 percentage points are due to the aging of the population.

The remainder is accounted for by the rising cost of care. And it is interesting to note, I think, that the elderly's out-of-pocket expenses for health care as a percentage of income are almost the same now as they were before the medicare program was instituted. That figure is about 20 percent of income.

Are we receiving better care today? Why does it cost so much? And what really can we afford? By bringing together providers and beneficiaries to discuss these issues, it is my hope that this hearing will contribute to a better understanding of medicare's financial status and the complex factors which must be considered in arriving at an equitable resolution of its problems.

I would like to explain briefly the format of the hearing. After the panelists have given their presentations, I will open questioning. I would then like to encourage an exchange of questions among all of us here on the panel, which I think will lend to a more interesting discussion. I hope no one will hesitate to ask questions of the other panel members.

Around 10:15 a.m., we will take a short break and, after that break, I would like to invite questions from the audience to any of us here on the panel.

If you prefer, you may submit your questions in writing on the sheets provided and I will ask as many of these questions as time permits. We will end exactly at 11:30 a.m., if not a little bit before.

The panelists are prepared to offer about 5 minutes of comments, but their full prepared statements will be included in the hearing record.

It is a great pleasure for me to welcome the panelists this morning. On my left, Dr. Marilyn Moon from the Urban Institute, Washington, DC; Hugh Smiley, chairman, Sedgwick County Council on Aging, Wichita, KS; Marlon Dauner, senior vice president, external affairs, Blue Cross/Blue Shield of Kansas, Topeka; Clyde Baker, president, District Lodge No. 70 Retirement Club, Wichita; Don Wilson, president, Kansas Hospital Association, Topeka; Pat Moore, Gray Panthers, Wichita; Dr. James Gleason, president, Kansas Medical Society, Topeka; Margaret Mullikin, Wichita State University Gerontology Center; Irene Hart, director, Sedgwick County Department on Aging, Wichita. It is a great pleasure to welcome all of you to this hearing.

Our first speaker will be Dr. Marilyn Moon.

STATEMENT OF MARILYN MOON, PH. D., WASHINGTON, DC, THE URBAN INSTITUTE

Dr. MOON. I am pleased to be here today to testify about medicare. In my several years as a medicare analyst at the Congressional Budget Office, I gained an appreciation for the complexity of the program and the difficulty of the problems facing it in the coming years.

I became convinced that the problems will not simply fade away nor will a painless solution necessarily be found. Sacrifices will be required. And I believe it is likely that it will be necessary to spread them among beneficiaries, taxpayers, and the providers of these services.

Consequently, I shall talk briefly today about the magnitude of the problems and about the tradeoffs implied by some of the options for approaching the problem. My written statement describes these issues in more detail.

In the next several years, as Senator Kassebaum outlined, the debate over the future of medicare will grow in intensity and magnitude. Federal expenditures on medicare totaled over $57 billion in fiscal year 1983 and at the currently projected rate of growth, spending will more than double by 1989.

Over the near future this projected growth in outlays is attributable primarily to rising medical care costs, including expansion in the volume of services provided under medicare, where volume refers both to intensity of care and to courses of treatment provided to patients. Depletion of the hospital insurance trust fund is projected between 1990 and 1995 unless further policy changes are made.

The year end balances in the trust fund will begin to decline later in this decade, leading to deficits which are small at first but then rise rapidly over time. Although the solvency of the supplementary medical insurance portion, which is paid for out of general revenues and premiums, is guaranteed, the 16-percent rate of growth projected for SMI causes problems in maintaining services over time as well.

Given the magnitude of the problems facing medicare in the next decade, some combination of available options will likely be required affecting three basic groups, providers, beneficiaries, and taxpayers. I shall describe three basic types of options that will likely be considered: First, options that affect the volume of services; second, options that change the level of reimbursements; and finally, options which require higher payments by beneficiaries or taxpayers.

Options for change that would reduce the volume or control the intensity of services will address some of the underlying causes of the medicare problem. Indeed, one of the criticisms often leveled at medicare has been the low level of control over what medical care services are delivered. Such options are, however, often viewed as less attractive when they would lead to dramatic changes in the way health care services are provided.

Often, for example, they would restrict choice by the user of services by limiting the types of services allowed, the place they are delivered, or who may provide them.

The essence of an approach emphasizing incentives for providers would involve changing the unit of service that is reimbursed; for example, paying a set amount for all medical services required by a patient over a year. The health maintenance organization is the best known of these types of institutions and it has demonstrated substantial reductions in volume compared with fee for service medicine. As a nontraditional approach, however, it has not grown as fast as many supporters would have liked. Moreover, it is not appropriate for all beneficiaries—for example, the very old.

The recently enacted changes in hospital reimbursement also alter the unit of services reimbursed. No longer do we pay on a cost basis for each separate test or service performed in the hospital. Rather, medicare pays on the basis of the entire stay, thereby eliminating any incentive to perform unnecessary tests or services.

Changes of this sort in the physician area are more problematic, however, since we are dealing with 400,000 physicians rather than some 6,000 hospitals.

Moreover, we have less control and even less information regarding physicians' charges under medicare.

Although the second major option, reducing reimbursements for each unit of service provided can produce short run Federal savings, such approaches do not directly address the underlying problems affecting medical care. Moreover, lowering reimbursements for providers could make other fundamental changes more difficult to achieve or aggravate problems with volume of services, thereby offsetting some potential Federal savings in other areas. For example, trying to achieve additional savings by further lowering hospital reimbursements at a point in time when we are phasing in the new prospective payment system may harm that system unnecessarily.

Restrictions on physician reimbursement through more stringent limits on the growth of reasonable charges or even a freeze on charges, as has recently been considered by the Congress, could achieve Federal savings. As long as physicians are not required to accept assignment, however, that is, as long as they are permitted to charge patients in excess of the reasonable charges that medicare establishes, a portion of budget savings from reduced reimbursements would probably be achieved at the expense of higher costs for some beneficiaries.

To avoid this, limits on growth in physicians' fees could be combined with a change in rules concerning assignment, although this could result in some physicians refusing to participate in medicare. The assignment issue is likely to prove a more important sticking point in seeking solutions to the SMI portion of medicare than freezes or other restrictions in payments would.

Finally, unless costs can be readily brought into line by changes in reimbursement practices or policies regarding coverage, it is likely that additional costs must be borne by beneficiaries, taxpayers, or both. Medicare beneficiaries could pay a greater share through across-the-board increases in premiums, premium in-

creases restricted to higher income beneficiaries, or greater sharing of costs by the users of such care.

Another way of implicitly making beneficiaries bear more of the burden is to raise the age of eligibility for medicare. Ways to make taxpayers pay more are obvious: by increasing revenues from payroll or other tax sources. Changes affecting beneficiaries would substantially increase out-of-pocket costs of the elderly and disabled.

While beneficiaries have not been subjected to major increases in cost sharing to date, they already pay about one-fourth of the rapidly rising costs of medicare-covered services and even more for other health services not covered by medicare. In 1984, an average elderly beneficiary will pay about $1,000 for insurance and medical expenses.

Choosing among strategies for having beneficiaries pay a greater share of costs involves important tradeoffs. Across-the-board increases would spread the burden among the greatest number of individuals, while tying cost sharing to use of services would have a somewhat greater impact on beneficiaries' incentives for use of care. Scaling some cost sharing or premiums to the level of income of the beneficiary offers a way to achieve some Federal savings while protecting those with very low incomes. Raising the age of eligibility may not place a great burden on elderly persons in good health still working, but recent changes in the law have attempted to require employers to carry a heavier burden of that cost anyway. Consequently, the Federal savings from raising the age of eligibility may come at the expense of persons in poor health who cannot work.

A final approach to medicare's financing problems would be to rely more heavily on tax revenues. Reliance on higher taxes would avoid increasing beneficiaries' out-of-pocket costs for medical services or reducing their access to quality care. But any tax increase implies that current taxpayers would be supporting a level of benefits for medicare beneficiaries that already is well in excess of contributions made by the participants.

In 1984 taxpayers will contribute more than $1,750 for each patient in the medicare program. Moreover, the payroll tax is currently the most burdensome tax on low-income workers since it allows no deductions or exemptions. Other taxes also pose problems, perhaps the greatest of which is the existence of an alarming Federal deficit and the implicit competition with other Federal programs for funds that results.

On that pessimistic note, I think I will let someone else talk who may have some solutions to these problems.

[The prepared statement of Ms. Moon follows:]

PREPARED STATEMENT OF MARILYN MOON

In the next several years, the debate over the future of medicare will grow in intensity and urgency. Federal expenditures on medicare totaled over $57 billion in fiscal year 1983 and at the currently projected rate of growth, spending will more than double by 1989. This giant Federal program has been and will likely continue to be subject to changes in areas such as reimbursement policies, coverage of services, the size and sources of tax support, and the structure of benefits. In my testimony today, I shall talk briefly about the magnitude of the problems facing medicare and some options for alleviating these problems.

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Over the near future, the projected growth in outlays is attributable primarily to rising medical care costs, and only to a lesser extent, to the aging of the population. A large part of the increase in costs is attributable to expansion in the volume of services provided—where volume refers to both intensity of care and number of courses of treatment provided to patients. With medicare committed to financing mainstream medical care for its beneficiaries, changes in medical care practice automatically reflect themselves in Federal outlays. Reductions in the general level of inflation in our economy and the changes in prospective hospital reimbursement have helped slow growth a bit, but the projected growth of medicare still remains at a much higher rate than those expected for other goods and services.

Depletion of the hospital insurance (HI) trust fund is projected between 1990 and 1995, unless further policy changes are made. While projections of Federal expenditures over periods as long as 10 or 15 years are very imprecise, differences between the expected growth of medicare and the revenues to support it are so large that errors in forecasting are relevant only to dates and amounts—not to the conclusion that under current policies, severe financing problems will occur. The yearend balances in the trust fund will begin to decline later in this decade, leading to deficits which are small at first but which will increase rapidly. These projections have been pushed back somewhat by the changes enacted in hospital reimbursement since 1981. But even the major changes introduced by the legislation have not solved the problem.

Although the supplementary medical insurance (SMI) program is partially funded from general revenues from the Treasury and hence the solvency of its trust fund is guaranteed, its rapid growth also raises concerns. In a period of Federal fiscal stringency, it is difficult to maintain a program which is projected to grow at a rate of 16 percent when revenues into the Treasury are rising at a much lower pace.

In a period of scarce resources, the choices for medicare are likely to result in either major changes in the way services are delivered or in how much people are asked to pay. These are not easy choices, but it is also no longer realistic to assume that the problems will solve themselves.

OPTIONS FOR SOLVING THE PROBLEM

Given the magnitude of the problems facing medicare in the next decade, incremental approaches are unlikely to provide solutions. Moreover, any single change in medicare large enough to solve the problem might have to be so substantial as to be politically unacceptable. Consequently, some combination of available options will likely be required, affecting three basic groups—providers, beneficiaries, and taxpayers. I shall describe three basic types of options: Options affecting volume of services; options changing the level of reimbursements; and options which require higher payments by beneficiaries or taxpayers.

Options that affect intensity or volume of services

Options for change that would reduce the volume or control the intensity of services would address some of the underlying causes of medicare's financial problem. Indeed, one of the criticisms often leveled at medicare has been the low level of control over what medical care services are delivered. Such options are, however, often viewed as less attractive when they would lead to dramatic changes in the way health care services are provided. For example, traditional payment methods that reimburse on a fee-for-service basis provide few incentives to providers or beneficiaries either to limit the number of medical services or to use a lower cost mix of services. A move away from the fee-for-service structure is likely to be viewed as "radical" approach.

The essence of an approach emphasizing incentives for providers would involve changing the unit of service that is reimbursed—for example, broadening further the unit of payment to encompass all medical services required by a patient over a year. The health maintenance organization is the best known provider organization that contracts to provide medical care on such a per-person basis and it has demonstrated substantial reductions in volume compared with fee-for-service medicine. As a nontraditional approach, however, it has not grown as fast as many supporters would have liked.

The recently enacted changes in hospital reimbursement also alter the unit of services reimbursed. No longer do we pay on a cost basis for each separate test or service performed in the hospital. Rather, medicare pays on the basis of the entire stay, thereby eliminating any incentive to perform unnecessary tests or services. Although it will take some time before we know the full effect on hospitals, prospective payment does, I believe, offer hope that medicare can begin to introduce

changes that will have positive effects on health service delivery. This is not to say, however, that the course of prospective payment will be a smooth one, but rather that it should be carefully monitored and nurtured.

Direct controls on providers by medicare or its agents thus offers another alternative to reduce the volume of services. Changes of this sort in the physician area are more problematic since we are dealing with 400,000 doctors as opposed to 6,000 hospitals. Moreover, we have less control and even less information regarding physicians' charges under medicare. Examples of more limited changes in this area are utilization reviews which attempt to reduce volume by identifying uses of services that depart from the norms of medical practice, limiting payment for difficult procedures to designated centers, and ending medicare coverage of very expensive procedures with questionable or small medical value. All these options would substantially affect a patient's freedom of choice in type or location of service.

Lowering reimbursements

Although reducing reimbursements for each unit of service provided can produce short run federal savings, such approaches do not directly address the underlying problems leading to higher medical costs. Moreover, lowering reimbursements for providers could make other fundamental changes more difficult to achieve or aggravate problems with volume of services, thereby offsetting some federal savings. For example, trying to achieve additional savings by restricting hospital reimbursements further during the phase-in of the new prospective payment system may doom that approach to failure.

Restrictions on physician reimbursement through more stringent limits on the growth of "reasonable" charges—or even a freeze on charges as has recently been considered by the Congress—could achieve Federal savings. Alternatively, more basic charges could be made in the structure of reimbursements for particular services or types of physicians, emphasizing options that might focus on the volume of services as well as their unit costs.

As long as physicians are not required to accept assignment, however—that is, as long as they are permitted to charge patients in excess of "reasonable" charges—a portion of budget savings from reduced reimbursements would probably be achieved at the expense of higher costs for some beneficiaries. To avoid this, limits on growth in physicians' fees could be combined with a change in rules concerning assignment, although this could result in some physicians refusing to participate in medicare, thereby limiting beneficiaries' access to care. The assignment issue is likely to prove a more important sticking point in seeking solutions to the SMI portion of medicare than freezes or other restrictions in payment.

Changes in payments required of beneficiaries or taxpayers

Finally, unless costs can be readily brought into line by changes in reimbursement practices or policies regarding coverage, it is likely that additional costs must be borne by beneficiaries, taxpayers, or both. Medicare beneficiaries could pay a greater share through across-the-board increases in premiums, premium increases restricted to higher income beneficiaries, or greater sharing of costs by the users of such care. Another way of implicitly making beneficiaries bear more of the burden is to raise the age of eligibility for medicare. Ways to make taxpayers pay more are obvious—by increasing revenues from payroll or other tax sources.

Changes affecting beneficiaries could generate relatively large amounts of Federal savings—although they would do so by substantially increasing out-of-pocket costs for the elderly and disabled. While beneficiaries have not been subject to major increases in cost sharing to date, they already pay about one-fourth of the rapidly rising costs of medicare-covered services, and even more for other health services not covered by medicare. In 1984, an average elderly beneficiary will pay about $1,000 for insurance and medical expenses.

Choosing among strategies for having beneficiaries pay a greater share of costs involves important tradeoffs. Across-the-board increases would spread the burden among the greatest number of individuals, while tying cost sharing to use of services would have a somewhat greater impact on beneficiaries' incentives for use of care. Scaling some cost-sharing or premiums to the level of income of the beneficiary offers a way to achieve some Federal savings while protecting those with very low incomes. Raising the age of eligibility may not place a great burden on elderly persons in good health still working, but recent changes in the law have attempted to require employers to carry a heavier burden. Consequently, the Federal savings from raising the age of eligibility may come at the expense of persons in poor health who cannot work.

A final approach to medicare's financing problems would be to rely more heavily on tax revenues. Reliance on higher taxes would avoid increasing beneficiaries' out-of-pocket costs for medical services or reducing their access to quality care. But any tax increase implies that current taxpayers would be supporting a level of benefits for medicare beneficiaries that already is well in excess of contributions made by the participants. In 1984, taxpayers will contribute more than $1,750 on average for the costs of care for each medicare beneficiary. Payroll tax contributions by employees and employers are already scheduled to increase by 1.9 percentage points between 1975 and 1990—a 31-percent increase. Moreover, the payroll tax is currently the most burdensome tax on low-income workers since it allows no deductions or exemptions. Consequently, for these and other reasons, it may not be the most appropriate choice for further large increases. Other taxes also pose problems, however. For example, general revenue contributions for SMI are already increasing at 16 percent a year. Revenue sources such as alcohol or tobacco or even inheritance taxes are not likely to yield revenues high enough to make major inroads, but perhaps should be considered as partial solutions. Revenues for medicare must, however, compete with other programs for Federal funds in a period of severe budget stringency and an alarming Federal deficit.

CONCLUSIONS

The projected growth in medicare outlays poses problems for controlling the Federal deficit and for insuring the solvency of the HI trust fund—problems which, without changes in current law, will continue for the foreseeable future. The size of reductions in outlays or increases in taxes that would be required to bring HI into balance over time suggest the importance of considering a combination of approaches to spread the burden among providers, beneficiaries, and taxpayers. In addition to these medicare-oriented approaches, a long-term solution to the problem of rising medical care costs would probably require changes affecting the entire system.

All of these approaches pose difficult tradeoffs, however. Raising taxes could leave medicare intact, but only at considerable cost to taxpayers. Obtaining savings exclusively through increased medicare cost-sharing or reduced reimbursements could lead to a second-class system of care for the aged and disabled. Options that seek major changes in the system may promise long-run savings but are difficult to implement if they are also required to immediately reduce costs. Systemwide attempts to contain medical care costs could ultimately result in slower expansion in services to most users of health care, although the impact on health care would be unpredictable.

Senator KASSEBAUM. Thank you. I would just like to say regarding Dr. Moon that she has worked for 2½ years as a senior analyst with the Congressional Budget Office. She is an economist and is now employed with the Urban Institute. So, her analysis of medicare is based on several years of thorough study of the issue.

It is a pleasure to welcome next Hugh Smiley, chairman, Sedgwick County Council on Aging. He is very active in a number of community organizations, including several that are particularly involved with senior citizens.

Mr. Smiley.

STATEMENT OF HUGH L. SMILEY, WICHITA, KS, CHAIRMAN, SEDGWICK COUNTY, KS, COUNCIL ON AGING

Mr. SMILEY. I want to thank you, Senator, for bringing this hearing to Wichita. Quite often taxpayers and voters feel their opinions are not voiced. I am happy to see that you have given an opportunity for them to say what they want to, or put it in writing.

What I have to say would not be as broad or as technical as what Dr. Moon has presented, but I do have some thoughts that come to mind and I hope that they will be helpful.

One of the questions I would raise concerning medicare is, What do present older Americans expect from the program and are they expecting more than it is intended to provide? I believe that many

older Americans are of the opinion that medicare is intended to provide for their total health needs and they therefore think that doctors and hospitals that bill them for more than medicare approves are not cooperating or something improper is taking place when they receive only a partial reimbursement.

Some suggested that we provide lists of doctors that take assignments and of course that is being done here in our community and our tricounty area. However, this presents a problem because many of the doctors do not take assignments from all that request it. And I can see an example of, say, an 80-year-old person, we say to them, "Now you have got to go out and shop around for a doctor that will take an assignment or be prepared to pay out additional money that you do not have."

This presents problems to both patients and their doctors. Often, charges by doctors—and hospitals—seem to be completely out of line. But as lay persons I think it is difficult for us to say, well, now that is out of line. We are not in that kind of business and we do not know what it takes to operate that kind of business.

But about all we can do is compare the present computerized world against the money that we earned in years past. And it is a little bit difficult to make that comparison. Sometimes I think the charges are high, but I would not have any basis to really prove that.

Perhaps one way to encourage physicians to accept medicare reimbursement as full payment would be to allow them some type of writeoff for the difference between the amount they charge and the amounts received for the services. The monthly deduction from social security checks to participate in the voluntary medical insurance program does not appear to be one of the problems so far as participants are concerned.

It no doubt is one of the problems so far as funding is involved. There are many thoughts being voiced involving medicare and many persons are saying that if something is not done soon, we will not be able to afford the type of health care we need.

Many persons have stated that the critical period is already here. One of the problems is that the method used in determining amounts to be approved; that is, those reasonable charges are not current. And I believe from what I have been reading that that runs from 6 to 18 months behind current charges. Even with those lower than average charges being approved, it is obvious that medicare funds are being expended more rapidly than income is being received for the program.

Another concern is the recently adopted diagnostic related groups, the DRG program. Families are concerned—and this has happened in my own community—families are concerned that patients are being released from the hospital before they are able to take care of themselves or there is no one at home capable of providing the necessary assistance.

Explanations I have heard from hospital personnel sound reasonable to me, and this type of a program is long overdue, mainly because of the abuse of medicare in the past. However, many older persons have difficulty in understanding what is being done, and therefore much inaccurate information is being circulated among the general public today.

Many doctors do not take medicare assignments and their charges are more than medicare approves, the dilemma being that persons cannot afford to be without additional insurance. The cost of the additional insurance is prohibitive to many of them also.

If a person has supplemental insurance, one solution would be to go first to the insurance carrier and then to medicare as a secondary carrier. And I just received a notice last week that this is being done for Federal employees over age 65 that are still working and also have medicare.

Most persons are aware that something must be done now—to increase finances to the program. I wish I had the solution. Some persons without realizing it are suggesting some type of socialized medicine. It is quite possible that will be the direction our country will eventually take. So far as helping fund the medicare program, I favor the excise taxes, not only on alcohol and tobacco, but also on other luxury items such as perfumes, playing cards, theatres, nightclubs, gambling, that type of thing. In addition, I would favor an increase in payroll taxes, but some assurance must be given to the person paying those taxes that the benefits will be available to them when they become eligible.

Thank you.

Senator KASSEBAUM. Thank you very much, Mr. Smiley. When you mentioned excise taxes, I was reminded that several weeks ago I received a letter from a constituent who suggested that we consider placing an excise tax on professional sports and allocating those moneys to medicare.

Next, it is a pleasure to welcome Marlon Dauner, who is a senior vice president with Blue Cross and Blue Shield of Kansas. Perhaps more importantly for the discussion today, he is the architect of the new competitive allowance program or CAP, which went into effect January 1. He is an economist and also has a masters in public administration from the University of Kansas.

STATEMENT OF MARLON R. DAUNER, TOPEKA, KS, SENIOR VICE PRESIDENT, EXTERNAL AFFAIRS, BLUE CROSS/BLUE SHIELD OF KANSAS

Mr. DAUNER. Thank you, Senator. I appreciate the opportunity to provide testimony today. I realize health costs are a major problem for the elderly; a major problem for the Government is financing health care for our society.

I think in order for us to develop a coherent policy as it relates to the financing of care at a reasonable cost, we do need to understand the components of health care costs. And we need to realize that it is a multifaceted problem. We have had tremendous advances in technology in the last 20 years, the introduction lately of the computerized axial tomography and magnetic resonance imaging equipment.

All of these things make the problems of people who are receiving health care different than it was 10 or 15 years ago. Also, general inflation affects our health care environment, just like in other segments of our economy. There are inefficiencies in the delivery system and they must be corrected. Health benefit programs such as Blue Cross, medicare have in and of themselves created de-

mands for medical care services and poured dollars into medical care. Paying on the basis of costs and disregarding efficiencies at various provider locations have also contributed to the problem.

Unhealthy lifestyles; and I doubt if any of us here smoke or drink or overeat, but I am sure there are people that do, place a burden on our society. Medical malpractice is another page in rising costs of health care, as are mandating benefits at both the Federal and State level, requiring certain benefits be provided. Inefficient health planning programs and uncoordinated facility development is also expensive.

As we have experienced a growing part of our population being considered elderly, we can anticipate that costs will increase because typically they require more care. One of the major things that we identified here in Kansas that we felt was a problem is that we have a lack of competition as it relates to the usual economic checks and balances within our economic environment of health care. That has to be changed.

I think we should also realize that there are going to be even greater changes in the future and costs may be anticipated to rise even more because of such things as organ transplants and the fact that we are going to be treating the chronically ill as our population gets older.

There are three major factors that I believe have restricted the development of competition in the health care environment. First is the unique role of the physician. The physician not only supplies services, but is instrumental in generating the demands for the services.

Physicians decide who is admitted to the hospital and how long they will be there and when they will be discharged. This has tremendous economic implication as it relates to the price of the given service and also the total cost of the service provided. The second factor is relative to hospital services, and that is up until the implementation of the diagnosis related grouping [DRG], by medicare, it was very difficult for a patient to actually determine the service that he has been receiving, the outcome, and associate a price tag with that to compare prices for services.

And the third factor is third-party benefit programs such as Blue Cross, medicare, other commercial carrier programs that pay on the basis of costs for the most part. That has got to be changed. It has to be a more price competitive environment. Also the benefit programs usually tend to remove the individual from any cost conscious decisionmaking as it relates to receiving services. People tend to view services as free, and that has tremendous impact.

In Kansas, as the Senator pointed out, Blue Cross/Blue Shield developed a new program, the competitive allowance program or CAP, initiated January 1, 1984, and the system employed a DRG based reimbursement system for hospitals. The DRG based payments are handled much differently than they are for the medicare program.

In Kansas, Blue Cross/Blue Shield pays hospitals their charges up to a DRG maximum payment that is a competitive maximum with other hospitals. We do not pay the hospital that DRG amount every time they have a patient. It does depend upon the length of stay and the charges the hospital has. Incentive payments are

available to hospitals and those incentive payments are given to hospitals who show a history of cost effectiveness in providing services to patients.

During the first 3 months of 1984 Blue Cross/Blue Shield experienced a reduction in cost per case of about 20 percent over last year's charges. And I certainly doubt if the medicare's program has experienced that level of reduction. We believe it resulted from a more efficient use of hospital services to respond to the incentives built into our system of reimbursement.

Physicians' fees have been identified in our CAP programs as increasing at a rate more in line with other segments of the economy, the CPI. In addition, we think that our utilization review program based upon severity and intensity data, which is also a unique tool to us, is a very adequate tool for helping physicians, hospitals, and third-party payers evaluate the appropriateness of utilization and service provided.

We believe the competitive allowance progran contains some competitive approaches in health care that medicare might find advantageous and as modifications and changes are considered to the prospective payment system. We would be more than willing to work with medicare in that process.

Also, in our system, it is required that providers contract with us on a calendar year basis. The reason we do this is so that the public will know which providers will in fact accept the payments as payment in full. For medicare you have that assurance as an elderly population seeking care in the hospital, because the hospitals are required to accept assignments; on the physicians' portion of the payment, they are not required to accept assignment.

I believe that this could be modified through offering contracts to physicians for medicare on a yearly basis, and physicians would elect to contract with medicare for the entire year, and in that process accept assignments for all eligible beneficiaries for all services during that period. This would give the beneficiaries more predictability in coverage and they could identify the physicians that they wish to seek services from based upon their desires in that area.

We believe there are other viable alternatives that can be employed to control health costs and to increase the finances available to handle medicare costs. There are three or four that are important, a few minor ones, that I think might also be considered.

First is developing a means test for medicare beneficiaries. There are medicare beneficiaries that can afford to pay for their own care, either through private sector insurance or on their own. And I believe that it is taxing the medicare system too much to allow those people to continue to receive medicare benefits. Also with respect to that, the initiation of a voucher system for medicare beneficiaries might be put in place so that there are benefit programs available in the private sector for offering to the medicare beneficiaries that they might have access to the health benefit program in some other way.

The medicare prospective payment system, although good, I believe could use some modification as it relates to both hospital payments and physician services. We believe that it could be changed to be more cost effective through price competition.

The third element is a provision for yearly physician assignments for medicare beneficiaries, in the form of contracts with medicare.

And then finally as far as the major activities, there is a need for improved health planning that considers new competitive reimbursement models as it structures health facilities and services throughout the United States. This could even include such things as being restrictive as it relates to licensing of organ transplant centers. Organ transplants are going to become a very, very costly item for the United States.

And if we are going to have that service available at all, I believe that it needs to be restrictive, and people may need to travel to specific areas to receive those services. Other alternatives such as taxing liquor and tobacco are probably good in that they may affect lifestyles—and the more unhealthly our lifestyles, the more demanding we are of our medical care system.

It is crucial that true cost containment in the medicare program or any other segment of health care programs be obtained through cost avoidance as opposed to the transferrence of cost from one payer to another or one payer to the individual beneficiary.

Cost transferrence can result from reducing the level of payments to providers with no provision for the provider to accept that as payment in full. In other words, they may also bill the beneficiary. It may also result through unrealistic deductibles and coinsurance amounts placed in the program. Cost avoidance, on the other hand, can be achieved through improving the deficiencies in the system, changing lifestyles, utilizing an appropriate place of service—using an outpatient setting as opposed to the inpatient setting—reducing the need to visit the hospital through outpatient services and reducing the inappropriate construction of facilities where they are not needed.

I believe I am going to stop there, Senator, and would be willing to expand on these comments later.

Senator KASSEBAUM. Thank you very much.

[The prepared statement of Mr. Dauner follows:]

PREPARED STATEMENT OF MARLON R. DAUNER

Senator Kassebaum, I appreciate this opportunity to testify at the Senate Special Committee on Aging hearing. As health care costs continue to rise, I am sure there are increasing pressures on Congress to address this issue, especially as it relates to the financial problems facing medicare and the financing of services for the elderly in our society.

In order to develop a coherent policy on financing care at a reasonable cost, it is essential to understand the components of health care cost increases.

Historically, costs have risen due to:

(a) Advances in medical teachnology—such innovations as the CAT scanner and magnetic resonance imaging equipment;
(b) general inflation;
(c) inefficiency in the delivery of services;
(d) health benefit programs—increased demand for services;
(e) medical care payment programs—cost and charge based systems;
(f) unhealthy lifestyles;
(g) medical malpractice;
(h) mandated benefits—Federal and State;
(i) inefficient health planning programs—uncoordinated facility planning;
(j) aging population;
(k) unnecessary and improper utilization; and
(l) lack of competition and usual economic checks and balances.

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In the future, even higher costs may be anticipated as we provide services such as organ transplants and care for the chronically ill. These highly expensive forms of care, in conjunction with new technological advancements, may force all payers of health care services in our society to introduce new coverage limitations into the health benefit programs. This, in essence, is a form of rationing health care.

As a framework for the analysis of health care costs and our decisions to control these expenditures, it is important to realize that addressing one particular cost factor alone will not resolve our problem. For instance, merely restricting payments to providers will not result in reducing the rate of increase in health costs to a level that the public can afford. Decisions made by the public, providers, regulators, and health planning bodies are all integral parts of reducing the rate of increase in costs. Public decisions affect lifestyles, demand for services, how we handle our aging population, and medical malpractice. Provider decisions affect utilization, demand generation for services, and equipment involves health planning and dollars available in our system for improved technology through research. Finally, the management decisions related to the limited health care resources affect technology, benefit programs, operating costs, health care markets, regulatory actions, third party payment systems, and pricing of benefits. To date, the lack of competitive forces in the health care industry have resulted in conflicting decisions by various entities in this framework. Thus, a somewhat inefficient and uncoordinated delivery system has developed.

Three major factors that have restricted the development of competition must be overcome. The first is the unique role of the physician. The physician not only supplies services but is also instrumental in the generation of demand for services. This has significant economic implications as it relates to cost and the establishment of prices within the health care industry. The second factor is the lack of a defined service at the hospital. Patients discharged from hospitals receive either very lengthy itemized billings or component billings related to such items as laboratory services, x-rays, etc. The consuming public has a difficult time relating to the charges of hospitals for an entire service such as the removal of an appendix. The diagnosis related grouping (DRG) system that medicare has employed may help in the defining of services rendered by hospitals and lead to a more price competitive environment. The third factor is the creation of third party benefit programs that pay on the basis of costs or charges regardless of the provider's efficiency. Also, these benefit programs remove the individual from the cost conscious decisionmaking process.

In Kansas, Blue Cross and Blue Shield developed a new program for reimbursing providers of care based upon the above considerations. The competitive allowance program (CAP) was initiated on January 1, 1984 for Kansas Blue Cross and Blue Shield subscribers. The system employs a DRG-based payment mechanism for hospital services and maximum payments for each physician service. The DRG-based payments to hospitals are handled much differently than the medicare approach. Hospitals are paid charges up to a competitive maximum price for each DRG. Incentive payments can be obtained by cost effective and efficient hospitals. During the first 3 months of 1984, the hospital charges per case for Blue Cross and Blue Shield subscribers have been reduced in excess of 20 percent of last year's charges. This has resulted from more efficient use of hospital services. Physician fees are increasing at a rate more in line with price changes in other segments of our economy. In addition, costly utilization review by a professional review organization has been avoided. Blue Cross and Blue Shield has developed a severity and intensity reporting mechanism through automated means that facilitates a more effective utilization review program at a substantially lower cost.

The competitive allowance program contains competitive approaches to health care reimbursement that medicare might find advantageous as modifications are made to the prospective payment system. Also, Blue Cross and Blue Shield contracting providers "participate" through a calendar year contract to accept the Blue Cross and Blue Shield maximum payments as payment in full for services rendered to subscribers. Although medicare has adopted a mandatory assignment for hospital services, physicians may select to accept assignment on a case-by-case basis. I believe this should be changed and physicians offered an opportunity to participate in medicare on a yearly contract basis for all beneficiaries. This would give the beneficiaries predictability of coverage based on the physician that they select. If this does not work, the alternative of mandatory assignment is still available.

Some viable alternatives that may be employed to control health cost increases and finance services include:

(1) The use of excise taxes on liquor and tobacco.

(2) Development of a means test for medicare beneficiaries.

(3) Modification of the medicare prospective payment system and the physician payment system to generate more effective price competition.
(4) A provision for yearly physician assignment for all beneficiaries.
(5) Restrictive licensing of organ transplant centers.
(6) Improved health planning that considers new competitive reimbursement models.
(7) The initiation of a voucher system for some medicare beneficiaries.
(8) Expansion of HMO options to medicare beneficiaries.
(9) Improved system of utilization review activities.

It is crucial that true cost containment be obtained through cost avoidance as opposed to the transference of cost to other payers or individuals. Cost transference can result from reducing the level of payments to providers with no provision for the providers to accept the payment as payment in full. It may also result from unrealistic deductibles and coinsurance amounts.

Cost avoidance can be achieved through improving efficiencies in the delivery of services, changing lifestyles, utilizing outpatient services, reducing the need to visit a hospital or doctor, and reducing the construction of facilities where they are not needed.

Senator Kassebaum, I again appreciate the opportunity to testify on this matter and would be willing to expand upon any of the comments made in this testimony.

FRAMEWORK FOR ANALYSIS OF THE FACTORS IN HEALTH CARE DECISIONS

A	B	C	D
PUBLIC DECISIONS	PROVIDER DECISIONS	CONSTRUCTION FACILITIES SERVICES EQUIPMENT	MANAGEMENT OF RESOURCES
— Lifestyles	— Utilization	— Planning	— Technology
— Demand for Services	— Demand Generation	— Technology	— Benefits
— Aging Population	— Pricing		— Operating Costs
— Malpractice			— Market
			— Regulation
			— Third Party Payers (Payment-Systems)
			— Pricing

Senator KASSEBAUM. It is a pleasure to welcome next Clyde Baker, who is president of District Lodge No. 70 Retirement Club. He is retired from Cessna where he worked for 30-some years.

Mr. Baker.

STATEMENT OF CLYDE BAKER, WICHITA, KS, PRESIDENT, DISTRICT LODGE NO. 70 RETIREMENT CLUB, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. BAKER. Thank you, Senator. It is a pleasure for me to be here sitting on this panel to let the people know where we stand. As for our club, we have one of the largest clubs in the State of Kansas. We are associated with the National Council of Senior Citizens and this is what we believe; this is what we are backing, anyway.

According to Senator Edward Kennedy and Representative Richard Gephardt, the Medicare Solvency and Health Care Cost Control Act would render medicare solvent between 1985 and 2005 as a result of systemwide cost savings and give the program a new surplus of $29 billion by 2005.

For the same period, nongovernment health savings would be approximately $2.4 trillion. To achieve these savings, the Kennedy-Gephardt bill would require physicians to accept assignment for treatment of medicare covered patients; limit the annual increase in payments to hospitals and physicians; include all insurers, public and private, in order to prevent cost shifting; to impose prospective payment mechanisms on hospitals and physicians; place limits on capital expenditures by hospitals; encourage development of alternative health care plans such as health maintenance organizations; and implement a permanent, nationwide system of cost control programs that would adhere to Federal guidelines.

For example, it applies to all health care payers, individuals, insurance companies, and the government. It does not just squeeze down on one or two federally funded programs, pushing costs to the private sector, as does the current policy.

It is targeted at the causes of rising costs, hospital and physician reimbursement methods, and the practices these methods encourage. It does not penalize people who need health care services in its attempt to control rising costs. It recognizes that the medicare program is only a victim, not a cause of rising health care costs.

Medicare's pending insolvency is only one of the symptoms of a total health care system problem. Rising costs of hospital and physician services must be controlled, not only to preserve medicare, but also to keep health care affordable for everyone without sacrificing quality or access.

Low income, poorly insured, and uninsured people, these groups have difficulty receiving adequate health care services under most circumstances. As the cost of care rises, this difficulty increases and programs designed to help become inadequate.

Older people, medicare does not cover 56 percent of the elderly's health care expenditures. Older people require services costing about three times as much as younger people. Therefore, increasing health care costs not only are a financial burden, but they are also a threat to the health of senior citizens. Recent budget cuts in medicare introduced under the guise of cost containment have only intensified the problem.

We have most of our people in our club—and I am not just picking on our club—but most of the people we talked to, the elderly, I am not talking about the young, but the elderly are widowed and

these widows have a hard time of even getting any other but medicare.

They do not have the money to do this when their husbands die. Most of our plants have another insurance for them which they do not have now. You have a pension from them which, when the husband dies and leaves a widow, she does not get that pension from most of these plants—she loses it. That leaves her just half of what her husband was drawing on social security.

So this is a burden on these widows. Sure, I admit that when we have a wife and man both at home and they are retired, that they have enough probably to take care of themselves. But at the rate these hospitals, doctors, and all is going up, it is going to make a heavy burden on these people to do here, and the widows especially.

We have so many widows in our club. They are really suffering. They do not go to the doctor and hospital when they need to go, and I think that is just what is happening over our country today. When a person needs to go to a hospital, they cannot afford to go.

And if we do not stop this one way or another, I do not know what is going to happen. I understood some of it. I already heard that the doctors and the hospitals probably agree. They say it is not too high. Well, I disagree. I think the hospitals are way too high. I think the doctors are way too high. And we can stop this here, whenever we let them try to be a millionaire in a year's time, I think if we could stop this here, we could take care of this very easily.

Thank you.

Senator KASSEBAUM. Thank you, Mr. Baker. Maybe we could get a response to your concern about hospital costs being too high from Don Wilson, who is the president of the Kansas Hospital Association. Mr. Wilson has served as chief administrator of two rural hospitals in Iowa. He also worked with the Iowa Hospital Association for 10 years. I think it is extremely beneficial for us in Kansas to have someone in this position with experience in both rural and urban settings.

STATEMENT OF DONALD A. WILSON, TOPEKA, KS, PRESIDENT, KANSAS HOSPITAL ASSOCIATION

Mr. WILSON. Thank you very much, Senator. I am going to focus my remarks on the effect that current funding is having on the hospitals of Kansas and some speculation as to what further funding reductions may mean and what may be some possible solutions.

If we go back and look at the health care delivery system historically, we basically go through three processes. Back in the 1950's, there was a national concern over access to health care services. In response to that, the Federal Government promoted the Hill-Burton program, which allowed communities at their discretion through some sharing of funds to construct community hospitals. And in response to that, several hospitals were built with these funds in Kansas.

After the access issue had been resolved, largely through the Hill-Burton program, the next concern was one of quality. And that was about the time that the medicare program began. And

through the decade of the seventies, the quality issues rapidly diminished. As the quality issues diminished, concerns rapidly came upon us regarding cost. And that is the current issue. Price is what is driving the system.

And so to address that cost issue, the methodology has been established called prospective payment or the competitive allowance program that Blue Cross is promoting. Basically what those programs do is establish a free standing price that hospitals will receive and will have to make do with.

No longer is the reimbursement to hospitals tied to the cost incurred by those institutions.

What I would like to do is give you some observations, and they are observations at this time, as to what effect this type of reimbursement methodology is having on hospitals.

Since the prospective payment system for medicare did not take effect until October 1 and since most hospitals in Kansas did not come under it until January 1, I cannot really base any of these early observations on that program. But before that there was another program called TEFRA, which had somewhat similar constraints and did have somewhat of the same effect, so there is some comparison there.

First of all, I would like to address the rural hospital setting. I think it is extremely important to the Committee on Aging that a majority of our older citizens live in the counties classified as rural in Kansas. There are 140,000 older Kansans living in these counties. And to them access to care is extremely important. We are finding that many of our rural hospitals are reporting to us on a very frequent basis that they are facing financial hardship because of a number of things, a declining utilization as changes in methods of treatment come about; technology, more strict utilization requirements basically diminish the number of admissions that come to their institutions.

But nevertheless these community hospitals that serve a distinct rural population are finding it increasingly difficult to fund their operations from the revenues that they receive from medicare, medicaid, Blue Cross, private industry, and other sources.

It is becoming much more evident that in order for them to continue to exist—and since most of these in the rural areas are public institutions—that they must use their tax levy that they receive from the counties to handle operational funding. Because of these problems, frankly, in the last couple of months I have had one hospital come to us and say they are going to close.

You know, it was just basically flat out, we are going to close, there is no way we can continue. That is going to happen. Now, that may not have a very noticeable effect as far as Kansas is concerned. But, I think that it is extremely important to that community that that hospital has served for several years.

And we have others that are voicing that concern, that they wonder how long they can continue to provide service. I think we are going to be without question faced with closure because the policy issue for that is at the community level. The community decides that it no longer has the ability to fund the hospital from the property tax. Then the hospital will close.

What happens is that out in the rural Kansas and particularly out in the western part, if we have a whole lot of this happening, then I think we are going to run into some serious access problems. I do not think we can deny the fact that if we have this, it becomes a problem that we may find that Kansans are going to be 40, 50, 60 miles away from hospital service.

I think that then brings back into play the access issue and what policy position we should take with that. So we need to, as a partial solution to the whole delivery issue of services, take a good look at what systematic changes may be necessary if we are going to be looking at a shrinkage of the system in the rural areas and how we distribute this.

Looking at the urban areas, the effect that we are seeing on funding in those areas basically are twofold. In the larger inner city hospitals where the predominant patient load is medicare and medicaid, again funding is becoming a very serious problem.

I can relate to you a conversation that I had with a friend that is involved with a hospital in another State, which is a very large inner city hospital. This sister is a friend of mine who has a mission to perform in a very large metropolitan area. In this inner city hospital that basically serves medicare, medicaid, the poor—she needs $55 million just to renovate this facility over the next 5 years. New payment systems really will not allow for that type of funding, and yet this hospital certainly does serve a distinct mission as it provides services and is, perhaps, the only access to services for that population.

This is the first group of urban hospitals that may be affected by funding cuts. We are also seeing that within the urban areas of Kansas, that most of the hospitals are going through layoffs. There are significant employee reduction programs currently taking place.

Now, as we look at this and as we look at some of the reasons behind it. Admissions are down. Patient-days are down. And that is one way, and probably a very positive way, to reduce the cost, as long as those people needing care are being taken care of.

And that will reduce the rate of increase as far as health care is concerned. But there comes a point—and I cannot tell you what that point is that under the prospective payment program, as I commented to some people, it shakes out the system. And without question, the system will become more efficient because the incentives do promote efficiency and that is good. But there comes a point, if the funds continue to be reduced, that we may find ourselves now on the cutting edge of dealing with the ability to provide quality and access.

There is a book that has recently come out from the Brookings Institution called "The Painful Prescription." And it deals with that issue, in that what happens when fundings get down to the point where we may be looking at, for example, the British system of health care and how receptive will that be to the U.S. population.

And there is another policy issue that we need to discuss. I think within the hospital industry, as we see the acute care services somewhat being reduced, that any Government policy programs must provide incentives for the hospitals to move into other human services programs, particularly in the rural areas.

If they are going to maintain any type of a delivery, they are going to need to broaden their bases because they can no longer depend on the acute portion of the operation to fund the facility.

So we are going to have to have flexibility. We do have some flex with what is called the swing bed program. I think we have to realize that the current funding that is available does not equal the available services, the access, the quality, and a rapidly aging population; that the Government through its funding mechanism at the current levels of service will probably not be able to provide that in total.

I fully do not expect when I reach eligibility for that program in about 20 years that it is going to be fully funded for me. I am prepared at that time to assume some or all of that cost because I think that is the most practical approach.

I think that we need to really kind of bite the bullet and start looking at some long-term solutions. Right now we focus on the problem with short-term solutions. We tried to band-aid this and band-aid that. I think we need to look at some long-term solutions. I think it would really be in the public's interest if we could develop a long-term solution that may very well show us where we are going to be 10, 20 years down the road.

I think we need to work toward that. I think we need to give those people that become eligible in 10 or 20 years an expectation of what the program will be like, just for the fact that maybe they need to be thinking now how they are going to prepare for it.

And so those are things that I think we need to be addressing. I think it is without question that if we are going to maintain the array of services that are available, if we are going to enjoy new technology, we are going to enjoy basically the quality of life services that are being created.

I recently looked at a publication that they call the Parts Catalogue. And it was all of the replacement parts that are available now for the human body. Leland Kaiser, who is a noted futurist in health care, made the comment a few weeks ago when I heard him talk that we are going to change the name of hospital to body shop because there is such an array of technology that will replace your elbows, your knees, your hips, and all those things that we are going to need with a population that has a high life expectancy and is going to be wanting to be very active. The parts do wear out and they need to be replaced.

So I think that the alternatives, the long-range alternatives, if we are going to continue the system is a cost sharing approach that needs to involve all of us.

Thank you.

[The prepared statement of Mr. Wilson follows:]

PREPARED STATEMENT OF DONALD A. WILSON

Medicare costs have increasingly been viewed as uncontrollable. In 1967, program costs were only $4.5 billion but have grown at 17 percent annual rate to over $50 billion in 1983 and have been projected to reach $100 billion by 1987. However, it is inevitable that national health care expenditures will continue to rise for several complex and interrelated reasons. The most significant factor is the rapidly growing aged population which produces a larger pool of medicare recipients each year, whose demands for health care increase geometrically with their age. As a natural

consequence of this graying of America, chronic disease is becoming a dominant pattern of morbidity.

Health care expenditures continue to climb, too, as new technology and intensity of services available in hospitals today extend life and provide cures for conditions that were hopeless a few years ago. Kidney dialysis and heart bypass surgery are two prime examples of this.

While the overall inflation rate has declined sharply in the past year, the decline in health care inflation has been more gradual, so health care costs are rising faster than several other sectors of the economy. Individuals have remained isolated from these economic considerations, however, because of medicare, medicaid, and private insurance. This isolation fuels demand, which increases utilization of services, which raises total health care expenditures.

While Americans are becoming more sophisticated about health and health services and making positive strides toward adopting healthier lifestyles, self-induced illnesses and injuries still drain our health care resources. Smoking, alcohol, and drug abuse, careless use of motor vehicles, nutritional abuse, stress and lack of physical activity continue to contribute significantly to the rising cost of health care.

Total expenditures in Kansas hospitals rose 13.6 percent in 1982. Major causes of the increase in Kansas, just as in hospitals nationwide, were a greater number of aged patients (Kansas ranks eighth among States with the highest ratio of residents age 65 and over), higher utilization, increased intensity of services, new technology, inflation, wages and benefits to employees, energy and the cost of needed equipment and facilities.

However, government attempts to control the capacity of the health care system, access to care, costs or utilization have in the past, been ineffective because of counter incentives or the lack of incentives, which have been incorporated into the program's provider payment and beneficiary coverage policies. Until last year the direction of government, since the inception of the medicare and medicaid programs, has been to seek to control the cost of the programs by gradually reducing reimbursement to hospitals rather than restricting eligibility, redefining benefits or implementing long-range program reforms.

With the enactment of the Tax Equity and Fiscal Responsibility Act (TEFRA) and the Social Security Amendments of 1983, Congress reversed the traditional process of health appropriations and revolutionized the traditional system of paying hospitals for inpatient care provided to medicare beneficiaries. These two legislative packages targeted hospitals for major health care reform, cutting from hospital medicare payments $480 million in fiscal year 1983, $1.4 billion in fiscal year 1984, $2.4 billion in fiscal year 1985 and $3.7 billion 1986. The projected impact on Kansas hospitals is a medicare payment reduction of $14.9 million in 1983 (affecting 75 percent of Kansas hospitals), $23 million in 1984 (affecting 67.9 percent of Kansas hospitals) $30.7 million in 1985 (affecting 63.6 percent of Kansas hospitals) and $37.1 million in 1986.

Yet with the implementation of medicare's new prospective payment system, new incentives have been created which can have an extensive, positive impact upon the financing and utilization of health care in Kansas and the United States. In Kansas, the savings to the Federal Government is already being demonstrated. The first quarter's data (October-December 1983) from September 30 fiscal year end Kansas hospitals shows an overall decrease in medicare admissions of 7.2 percent from the first quarter of 1982. The largest hospital in this group registered a 9.6 percent decrease.

Nonetheless, any positive impacts are incumbent upon the payment of a reasonable price for inpatient hospital services. The current DRG rates have already been established based upon a roll-forward factor which is less than actual inflation in the hospital sector during that period. Thus, hospitals must immediately implement cost saving strategies to stay within the prospectively established Medicare prices. Numerous accounting, reporting and operational changes must be made. Meantime, hospitals must continue to compete in the labor market with private industry and government agencies, pay the mandated increased FICA taxes, face increased utility rates and other increased costs of doing business. Caps such as experienced under the economic stabilization program will not work. A reasonable price—a price adequate to cover the cost of caring for medicare patients—must be maintained. Arbitrary cuts to these prices can only succeed in strangling individual hospitals and collapsing this country's hospital system.

Furthermore, so much has been changed with TEFRA and now PPS in such a short time frame, that hospitals are beginning to be faced with not being able to respond. Not even the Health Care Financing Administration can keep up with the change needed in such a short time frame. Many questions and policy problems

with PPS are still hanging unresolved. Therefore, the real impact of what has already been established cannot even be completely assessed. Before further hospital payment policy changes are considered and implemented, all parties need the opportunity to evaluate what has been done and its full impact on the Nation's health care system in order to know what yet must be addressed. California Representative Henry Waxman stated it well when he said, "The success of Medicare has led to its current problems. People are no longer concerned about lack of access or quality. Technology has added to services available and the quality and length of life. We have finally arrived to the point where the demand and services available outstrip our ability to pay for them. The tough questions and issues to deal with are now on our doorstep."

The approaches taken to date have failed to take into account such forces as an aging population, exploding medical knowledge and new technology, inflation and the insatiable appetite for more and more when health care is "free." The time has passed for government to rely on changes primarily to hospital payment policies to control areas where personal choice is the critical ingredient. The placement of incentives throughout the system is where the promise for future constructive reform lies. Physicians, nursing homes, other health care providers and medicare beneficiaries must be similarly influenced by new incentives and payment systems. The government must return to individuals opportunities and incentives to make cost-effective decisions about access to care, appropriate levels of expenditures and the optimum supply of resources which are to be devoted to health care. Clearly, society and the health care industry must reconceptualize their roles and expectations and reestablish priorities which are consistent with available resources. We all must work together to resolve our problems and deal with the challenges before us. Survival is no longer an academic topic; it is today's reality.

Senator KASSEBAUM. Thank you very much, Mr. Wilson. Our next panelist is Pat Moore, who is one of the founders of the Wichita Chapter of the Gray Panthers. She is a homemaker who has always been very involved in community concerns and is also now a member of the Gray Panthers National Steering Committee.

STATEMENT OF PAT MOORE, FOUNDER AND COCONVENOR, GRAY PANTHERS OF WICHITA, KS

Ms. MOORE. Thank you, Senator. When, many years ago, I needed a certain number of credits at a certain time, I found a course called statistical analysis. In the first class the professor, using the very best charts, graphs, and figures proved beyond any reasonable doubt that if one fed one's child mashed potatoes before the age of 4, that child would be a juvenile delinquent before the age of 16. Since that time I have very little faith in charts, graphs, and figures which can so easily be manipulated to prove whatever one wishes to prove.

Rather, the Gray Panthers of Wichita address the human side of these issues. We are especially concerned with the responsibility for the outrageous and inexcusable raise in the cost of medical care to those least responsible for those raises, the patients. We find it also incredible that medicare and the insurance carriers continue to pay for the unnecessary test and X-rays administered to patients and for the excessive costs of simply things like aspirin. We are amazed that medicare and the insurance carriers will continue to pay the excessive raises in the cost of malpractice insurance which are added to those costs, which are passed on to the patients and the taxpayers.

We are horrified that the medical profession does not police itself and rid itself of those doctors who are not fit to practice and hence cause all of the excessive costs.

Forcing patients to limit their medical care by charging them too much is a nearsighted view of how to cut costs and can only result in greater charges to the welfare system and more taxes from the pockets of the working people.

We people on fixed incomes cannot pay anymore. We are a society which pays for "health insurance" when we should provide "wellness" insurance so that good health habits and preventive medicine could help keep those high costs down. We assure you the only results from charging more to the patient will be more taxes paid by the workers who are already paying more than their share.

In the United States today there is a price for being old, poor, a member of a minority race, disabled, or a dependent child. That price is fear, degradation, and death without dignity. We find it totally unacceptable that our Nation can pride itself on how much it gives to other nations while it cuts help to its own citizens.

Our own old, poor, disabled, minorities, and dependent children are becoming second-class citizens just because they exist. This is a shame of our Nation.

The Gray Panthers find much distress among those with whom we deal. What others call apathy is, in reality, despair and depression. People are stripped of dignity, of self-respect, and of that independence which is the pride of our citizens. Through no fault of their own, they find themselves at the mercy of Government agencies.

People are forced into molds which make it easier for the agencies to deal with them, but which strip them of every last trace of human dignity. Old people are entertained and patronized. Rules and regulations make it impossible for people to feel they have any control over their own lives.

Many of us tried to provide for our own old age, but major rises in all of our expenses have resulted in more and more people dropping below the poverty line. People of great pride and dignity will starve before they will ask for help. That so many people are shuffled off to the nursing homes is the crime of the century and should be the shame of those corporations which feed their greed on the needs of the old and helpless.

The medical profession is very pleased at the way in which they have extended the lifespan. We who are old wish someone would think more about the quality of that life.

Thank you.

Senator KASSEBAUM. Thank you very much. Next is Dr. Jim Gleason, who has practiced for over 20 years in my hometown of Topeka and has served as chair of the medical society's legislative committee for over 7 years. He has given a great deal of time, effort, and study to sharing the concerns of the medical profession with the public. His work has contributed to a better understanding of problems that we all share. Dr. Gleason.

STATEMENT OF DR. JAMES GLEASON, TOPEKA, KS, PRESIDENT, KANSAS MEDICAL SOCIETY

Dr. GLEASON. Thank you, Senator. This is a very complicated problem that makes it very difficult to relate in some way to some of the things that have been discussed this morning. But I want to

talk about a few of those things, and I am going to change what I am talking about relating to some of those that have just given their thoughts.

The medicare system probably has worked pretty well, maybe too well, if you are looking at a length of life. If that is the way you look at it—we do not, as physicians, look at it that way. We think that women living to be at least 77 years of age and men to 71 has really been very helpful.

I think that the success of the system is our basic problem. And we are related to it here. As many of you know, of all the people who ever lived to be 65 in the world, 50 percent of them are alive today; and 40 percent of all the medical costs that will occur will occur in the last 2 weeks of life.

So, if you address those two factors together, you can see the kind of problem that we are basically talking about. We have been involved in the prospective payment system recently and as Don said, I think it is probably too early to basically tell what the total impact is. But I think that there will be some great impact as far as that is concerned.

The length of stay is down; we are getting patients out of the hospital quicker. Sometimes, it has been more historical than medical how long patients have stayed, but I think we are taking a very hard look at that and trying to make it different, as far as the costs are concerned. Certainly, the use of outpatient services has been very helpful in relating to decreased costs.

I have one basic problem, however; there are incentives to physicians to do certain procedures on an outpatient basis, whether it be freestanding, or in an outpatient service, within the hospital, or in your office. Some of those incentives do not have anything to do with quality of medical care. I can receive more money, for example, by doing something in my office to a certain degree, and some of those things should never be done in the office.

And so, I think physicians are saying, "Hold on, we are not going to do these kinds of things." And we are being criticized for trying not to do the total cost related to this. But someone in this system has to look at quality. I realize that quality may be something ill-defined, but I think that all the governmental agencies, all of these programs, insurance industry many times is much more interested in the cost of things than they are basically in the quality of care.

I also think that the 65 year old that we have today is certainly not the same 65 year old we had 15 or 20 years ago. They are in much better health, for the most part, than they were before. And I think that it is true for all of us, not just the elderly.

But I think all of us are going to have to basically deal with the whole system of how we live because certainly wellness can make a basic big difference as far as the total cost of health care. And why is it, if you are going to smoke three packs a day, that society should pay for your carcinoma lung that you may not have had if you had not done those kinds of things.

And I think all of that becomes related to the total health care when you are looking at it. I think that the importance of taxes on the various things to try to increase some of the costs to pay for some of the costs are basically very important.

Now, I am going to talk a little bit about the mandatory assignment because obviously we have a difference of agreement, and try to bring in some of the sides from the physician's aspect. There are about 40 or 50 percent of us in this State that do accept assignment. Some of us selectively, but a lot of them totally.

And I think that that shows an interest in that, but I think all of us here, you have to look at it from our perspective. Fees in Kansas, physicians' fees in Kansas are about 20 to 30 percent less than the national average. We obviously in this area have attempted to be appropriate. AMA has now come out with a voluntary freeze on our services, our fee for services.

Lots of people think that is just rhetoric. I do not happen to think that it is. And the Kansas Medical Society has endorsed this concept, and going throughout the city I think that most physicians are very willing to go along with this under the circumstances.

I think that they are willing to do this in line with several problems that we have in the State. The professional liability is an outstanding problem. And being an obstetrician, I am probably a little more sensitive to it than maybe some of the others are concerned.

But most physicians who are having problems with professional liability are obstetricians, but they are the orthopedists, people who do the total hips, total knees, shoulder, whatever you are talking about, cardiovascular surgeons who do all these things that really make a big difference as far as the quality of life or what we are doing. The problem is, in deference to some people, is we do not necessarily have the control over malpractice costs, as you might assume.

Certainly, the malpractice costs have gone up in this State, somewhere between 75 and 100 percent for every doctor in this State this year, will rise another 75 percent next year. And that is not talking about people who have had any suits. So that is the sideline that is basically going on. And when you cannot basically control some of the things, then it becomes very difficult to look at the total picture.

My concern with accepting assignment is not basically a philosophical one. I think that everybody should have an opportunity to decide who they want to see as a physician, and the physician has some say in that. And what people are going to do is take away in essence some of that.

Now, we might have an excess of physicians; I think that that may be a moot point if things continue because in my traveling throughout this State I have found a lot of physicians becoming very confused about the system, uncomfortable with the system. And many of them are going to retire early, if they can, because of the paperwork that becomes involved relative to it, the controls that are related to that.

So, the overheads that continue to go up, and our overhead now is about over 50 percent in most doctors' offices that we are seeing, and some of that again I say we may not basically have as much control as we would like, will make people look at their differences in seeing different kinds of patients related to it, welfare patients, the regular patient, and the medicare patient that are a part of it.

The reason I say it is somewhat difficult, being an obstetrician and a gynecologist, my practice as far as medicare patients may be

10 percent or 15 or 20 percent, but whether you have physicians out in smaller communities where they are talking about 75, in some cases 80 percent, then you are talking about a different kind of style as far as the practice of medicine is concerned.

Certainly, internists who deal in this area are almost at 100 percent. So keep that in mind when you are looking at accepting assignment. Accepting assignment has nothing to do with economics, because economics are basically all receipts. Physicians get credit for a lot more things than we basically can do. We get credit for all the hospital charges when indeed we do not say what the hospital charges.

I am not saying they are overcharging; I am saying we do not control that. We do not control the costs to do our different testing. And again, here is a professional liability problem that hangs its ugly head, because if we let a patient go home too soon, we are pushed to send the patient home too soon, or we do not order the appropriate test, then a suit may follow, where all of the system is attempting to keep us from ordering as many tests as we should, appropriately, but hindsight is always 20/20 when you are looking at it on the professional liability situation. So I think that that is extremely important to look at.

Trying to tie acceptance of assignment with hospital privileges I think is extremely difficult for physicians, because I think that with doing that, that takes over the total practice rather than part of the practice. And I think the access that patients would have related to that will drastically drop.

In all this system physicians may appear to be the bad guys, but that we are not. We are attempting to do an appropriate job, but realizing that any procedure—anybody in this economical system has to have some purpose, has to have something for what he is attempting to do.

I am proud that our people are living longer. We are very anxious to become involved in a system that will extend that care and make it become better, but please give us an opportunity to have a say-so and not lip service. And I think that that is where many people in the industry are concerned that people outside of the industry are making decisions and they are not considering the feelings about the people in the industry.

We need to work hard to make the system work.

Senator KASSEBAUM. Thank you. Margaret Mullikin has a long history of involvement with aging issues and is associated with the Wichita State University Gerontology Center.

STATEMENT OF MARGARET MULLIKIN, WICHITA STATE UNIVERSITY GERONTOLOGY CENTER, WICHITA, KS

Ms. MULLIKIN. Thank you for this opportunity to speak to the Senator and to the audience and to the rest of the press, whoever. I would like to preface my remarks by suggesting that any of you who are interested in the hearings that have already been held concerning medicare take advantage of the materials the Senator has made available to you out there on the table this morning.

I have read every word of them. They contain some beneficial information and any of us who are interested in the many aspects of this problem should become informed.

A great deal of what I have prepared to say has already been spoken of from perhaps some of the different perspectives than those which I have developed. So, therefore, some of my remarks will be repetitive, I am sure.

There is no question but what the medicare fund is facing problems. I am not at all sure that we, the recipients of medicare, or we as taxpayers really have any control over the solutions to those.

As a consumer of sickness care, and in my judgment the term "health care" is a misnomer as yet; 20 years down the line we may have some kind of a health care system, but now to me what medicare is covering is sickness care.

As medicare recipients, we do not have much control over the cost of tht care; we have grown up with the idea that the person to go to when we are sick is our physician. This physician determines the diagnosis of our problem, prescribes the treatment, admits us to the hospital if he considers it necessary, dismisses us.

If we are made aware of the cost of that process before it occurs, it is a very rare occasion, and if we are sick, we are very likely not to go do much shopping. Shopping for a care of sickness condition is not exactly the same as shopping for a new automobile, and for those of us who have supplementary medical insurance, I am not at all sure that we have made it our business or that our insurer has made it his business to advise us of the probable costs of any sickness that we may have.

Therefore, my conclusion is that the consumer has had darned little to say about what a particular spell of illness was going to cost him. Neither have consumers had anything to say about the expansion of service facilities. I think, if my memory serves me correctly, this morning's paper made some reference to the fact that we now have an 800-bed facility, a 750-bed facility, a 600-facility, and the other one I do not remember, hospitals in Wichita.

How many of us as users had anything to say in the construction of those facilities? And again, if I read the article correctly, the occupancy rate is running between 60 and 65 percent.

I would like very much to know how much those unoccupied beds are in any way charged to medicare expenditures. Neither have we really been consulted on the addition of high technology facilities. I believe, if I am not mistaken, each of the Wichita hospitals now has a CAT scanner, which according to some of the information, run approximately $1 million apiece. Did any of us who use those have anything to say in the purchase of those?

In addition to that, of course, the costs of the highly trained personnel to operate those adding another cost over which the consumer has nothing to say. Now, it is true that there is a system—that apparently has not worked—in cost control known as the certificate of need mechanism. And for some reason that simply has not operated too well.

So, it seems to me that the providers and the third party payers are going to have to find some way to reduce costs. Consumers are going to be willing to cooperate.

As a matter of fact, I strongly suspect that it is the cooperation of the consumers that has probably had some effect upon the reduced usage in the hospitals that has led to the increased lack of occupancy. It perhaps is not appropos to this discussion, but I was struck by the fact not long ago that when consumer conservative usage of electricity led to a suggestion on the part of the utilitiy that that had cut down their costs so much they were going to have to raise their rates.

I wonder if we do not have some sort of a similar analogy in the hospital cost situation; as usage has decreased, costs have continued to rise. And it seems to me that we need to say then to the providers and to the third party payers, both public and private, the horse is already out of the barn. Now what can you suggest to do to correct it? We will be willing to go along with you and do what we can, but the cost should not be placed on the medicare recipient, most of whom are the least able to pay it.

Neither should it be placed on that payroll recipient who is already picking up a considerable burden of the cost. And so it may very well mean a considerable amount of belt tightening, but if we are going to be blamed for the cost of the service, then it is high time that we began to be consulted about some of the types of that service.

Now, I think that I should make some comment here to the fact that it is true that the citizens of the United States have come to the place where they expect their sickness to be treated as a right, not a privilege. This means then that they also expect access to service. And they expect that those services be good.

But, as was pointed out by somebody else, quality of care is something that is not very clearly defined either in the mind of the recipient and perhaps not even a great amount in the minds of the service providers.

The one thing that I know is that it cannot be expected of the medicare recipient, particularly after age 75 when he or she becomes more vulnerable to try to fill that gap, because it just cannot be done. They do not have it.

You are not only talking about a more vulnerable population who is sick or more likely to become sick, but you are also talking about a more vulnerable population economy wise.

I would like to make one reference to the DRG concept. And I am glad that it is going to be tried, but I think it should be carefully monitored. One of the things that I fear in relation to it is that it may very well result in simply a matter of cost shifting. One of the things that is happening—and we have seen some of it here in Wichita—as older people are dismissed from the hospital at an earlier point in time, they are not able to go home.

They are then sent to nursing homes, which means then that the nursing homes are going to have to provide not only a more intensive form of care, which is going to be more costly, and is going very quickly to reduce that recipient's ability to pay at a much sooner rate.

Already, of the nursing home population across the Nation, 50 percent of it is paid out of medicaid funds. In Kansas I think it runs 47 to 48 percent.

But what this may very well mean is that the DRG's, which result in earlier dismissal, is going to increase the cost and the need for nursing homes, which is going to shift the cost from the Federal Government to a Federal-State shared program. So, either way the taxpayer is going to pick it up. So, I think that this calls for a careful monitoring.

Another thing that it seems to me needs to be considered—and I intend to have questions later for this—but I do know that on a limited basis in some rural hospitals in Kansas, the swing bed concept is being used. And for those who do not know what that is, it is a matter of shifting unoccupied beds to long-term care at a reduced rate over their usual hospital rate. And it seems to me that this would be certainly one way that those empty beds might be used.

One other point that I want to make, I think that there is a great deal of dedicated care provided for patients in hospitals. But I am not at all sure that all of that care that is provided is totally efficient. I know of one unpublished study that shows quite inefficient use, as a matter of fact, of highly professional care. I would suggest that what has been found in other industries might very well be true for the hospital industry, and that is the workers out there on the scene may very well know a darned sight more than management about how efficient operations could be achieved if they were given the chance to do so.

I think perhaps I've used my time, and I thank you.

Senator KASSEBAUM. You have used it very well, as always.

[The prepared statement of Ms. Mullikin follows:]

PREPARED STATEMENT OF MARGARET MULLIKIN

Senator Kassebaum, I am honored to have been asked to offer my thoughts on the escalating costs of sickness in our society and the impact of these on the older population. I do not intend to review the statistical data concerning these costs. That has been thoroughly presented in the two hearings held last year by the Senate Special Committee on Aging under the chairmanship of Senator Heinz. In my opinion, the testimony given in these hearings provides excellent information as background for hearings relative to the question, "What can reasonably be done to make care of the sick affordable?" A related question would be what can be done to continue to make medicare a viable and affordable program for care of the ill elderly?

I would like to preface my later remarks by a few general observations based on reading these hearing reports and on materials published by AARP (American Association of Retired Persons).

First, most of the citizens of this country have, over time, come to look upon treatment of sickness as a right rather than a privilege. They may differ in deciding how this is to be accomplished or how much they are willing to pay but they seem to generally agree on two things: (1) That no one should be denied access to care; and (2) that there should be no difference in the quality of the care provided.

Second, there is a general concern in the adult population on how the high costs of sickness would be met if it should occur. Although this concern is noticeably high among older persons because they realize the greater vulnerability in advancing age, the concern is by no means limited to them. Younger families are fully aware they need insurance coverage for possible illness.

Third, there is a general belief that medicare must be maintained, and this is true of younger age groups as well as the aged.

Fourth, the abundance of statistical data on how the "health care" dollars have been and are currently spent clearly point to several facts: (1) Hospitals receive the greatest share of those dollars and provide the most costly services; (2) the increases in hospital care have been the greatest of any care services providers; and (3) hospital costs do not seem to be related to demand, utilization, or reduced inflation; more people use outpatient services, empty beds increase and so do costs; CAT scanners when first introduced cost approximately half what they do today, even though in-

creased demand should result in lower production costs; length of stay in hospital goes down and per diem hospital costs go up.

There seems to be one clear message in the statistics on costs of care of the sick in the United States. Something must be done to reduce the annual rate of increase in those costs, and that reduction must start with hospital costs. How that is to be done will not be easily decided and it will require the cooperative efforts of hospital management, third-party bill payors (both public and private), and consumers. It seems to me that one fact that must be faced is that the "horse has already gotten out of the barn" and any measures taken to secure him again will entail considerable fence mending.

As the research and reporting clearly point out there have been several conditions in the past that have led to our current dilemma. One, the policies that have guided reimbursement of hospital charges that have been based on cost plus. Two, has been the expectation of the consumer, and in my opinion, some misjudgement of those expectations. It is true tht U.S. citizens have come to believe that the care system can be expected to perform miracles in treatment and they expect the best. I do not believe they have expected their hospital accommodations to approximate the Conrad Hilton.

I also think the consumer is more excusable than are either the providers or the payors. In the first place, he is in the hands of some one whom he trusts—his physician who prescribes his treatment, admits him to the hospital and determines his dismissal. He seldom knows in advance what the costs will be and as long as his insurance coverage takes care of most of it he probably doesn't raise questions. Some of the testimony before the Senate Aging Committee stated that physicians would receive a higher fee for visiting patients in the hospital than they would if the visit was in the doctor's office. How many recipients of care know that and why should the fee be higher? With the medicare recipient of course, part A is paying the bill and the older person is unlikely to know the physicians charges. Itemized charges are not shared with the patient until after his hospital stay or after the services have been delivered.

Hospital costs have to be related to the growth in facility size, services offered, technologies used, and skilled help to make use of the technology. Somewhere the certificate of need mechanisms haven't worked as they were supposed to do to control growth. Competition has seemed to be the guide and has resulted in high costs associated with over supply of beds, partial or unnecessary use of machines and probably inefficient use of skilled workers.

The result in Kansas has been an over supply of services and costs that continue to rise each year at an alarming rate. All of the conditions that have led to increased hospital costs have impacted on older people. Part A of medicare has paid for about 45 percent of the care for most recipients on a cost plus basis until October 1, 1983. Private insurance for those that have it, helped to pick up the balance. For the poor elderly, medicaid has paid the bill as it has for about 50 percent of those in nursing homes. Now, the medicare fund is threatened and there is no way that the projected shortfall can be met by retired persons on fixed incomes. Nor should working people be expected to have their deductions increased to do so. Each of these groups could contribute, workers by some small increase in deductions, older persons by giving up some benefits up until age 75 when vulnerability increases. In fact, the Harris survey funded by Equitable indicated that some such changes would be acceptable.

But effective change has to be through cost control and that must be systemwide. Only the providers and the payors can manage such a change and the changes must avoid producing fear that severe illness will result in economic ruin. Families have had to learn how to live on reduced income. So must the providers. They have had nearly 20 years of unrestrained income. The time has come when efficiency of operation and budgetary analysis is necessary. There have been some suggestions made for lower cost delivery that should be explored and/or expanded. In medical care and treatment of some chronic illness, nurse practitioners could conceivably reduce high cost hospitalization; use of the "swing-bed" concept for long-term care in hospitals with low occupancy instead of building more nursing homes should also reduce costs. Fully utilizing high cost technology such as a machine in one location rather than in all hospitals in the area should reduce costs.

One of the factors in hospital costs that is frequently mentioned is labor costs. The persons who provide patient care have traditionally received low pay, but they might very well be able to see ways in which more efficient service could be provided if the formal structural arrangements could be modified to encourage them to express such ideas.

The DRG concept now applied to medicare should be considered for all age groups and should be closely monitored. The hospice programs may also have some effect since the research shows that the greatest cost for treatment of older folk occurs in the last year of life.

Medicare cannot be permitted to lapse, neither can it be converted to a means tested program. It would be acceptable, I should think, that a surtax could be imposed on high income older people similar to the one to be imposed on social security recipients beginning in 1985. But the medicare program constitutes a compact between the government and older people and it is not the people who use it that abuse it.

There has been considerable emphasis on self-care as a preventive measure. Only the morbidity rates in the future can provide answers on the effects of these on costs. As an analogy, Kansans have become so effective in energy conservation that the energy providers repeatedly ask the Kansas Corporation Commission for permission to raise rates because consumption has declined. Is there any reason to believe that providers of sickness care would react differently to decreased demand?

I would urge those examining the programs that provide sick care for the elderly to be aware that the DRG incentives to hospitals may result in considerable cost shifting from the hospital to the nursing home with a subsequent shift from medicare to medicaid. Since medicare pays for care only in skilled nursing facilities, I would assume that States other than Kansas have few SNF's. If sick people who are discharged from the hospital still require care that cannot be carried on in the home, the only other care facility is the nursing home. Private funds would be exhausted much sooner than they now are and medicaid would be the only funding source. Since this is a Federal-State shared program, the many problems that already plague the nursing home industry would be multiplied including lower quality care.

As a closing thought, perhaps we should ask ourselves if individuals shouldn't be permitted to make some decisions concerning the use of costly life prolonging technology. If the older person prefers to die with dignity, let him; and if parents of a severly handicapped infant prefer to let nature determine the outcome, honor their wishes. Scientific research and its application have provided us with a very high standard of living including care of the sick. There is, however, a point beyond which the quality of life becomes very low and science has not conquered mortality, nor has it obliterated the pain of sickness, its treatment and hopelessness.

Senator KASSEBAUM. Irene Hart is director of the Sedgwick County Department on Aging. She has been serving there for about 6 years and is very involved in the issues facing us here in Sedgwick County.

STATEMENT OF IRENE HART, WICHITA, KS, DIRECTOR, SEDGWICK COUNTY, KS, DEPARTMENT ON AGING

Ms. HART. Thank you. In some ways being the last speaker before the break is somewhat akin to giving the invocation at a luncheon; you have some pressure to get on with it. So, that is what I will do.

Part of my job is to coordinate Federal, State, and local resources, to put together a community services system that meets the needs of older people in our local area. Not only are we servicing Sedgwick County, we have some responsibility in Harvey and Butler Counties. There are approximately 64,000 people over the age of 60 in Sedgwick, Harvey, and Butler Counties.

We have recently commissioned a survey with the Wichita State University Gerontology Center and received some preliminary results from that survey. Some of those findings may be of interest to you. And if we can apply the figures from the survey to the general public, it gives an indication of the problem that increasing health care costs is causing to older people.

Utility costs were the primary cause of concern to most older people. Health care costs were second. Nearly 20,000 people in the

3-county area said that health care costs were causing them some difficulty in making ends meet. But nearly another 3,000 were saying that health care costs were causing severe difficulty in their making ends meet.

Figures given earlier today indicated that an average person spends about 20 percent of their income on out-of-pocket health care costs. The survey indicates that over 2,000 of those 64,000 are living on incomes of less than $5,000 a year. So the out-of-pocket costs affect different income groups differently.

But we are very concerned about the lower-income people who cannot afford medicine, transportation, and a number of other types of services. I am not an expert on health care policy, and I do not have a magical plan to resolve the problem, but based on our experience in developing community services, we believe this system's components are highly interrelated. That means that fixing any one component such as medicare will have wide ramifications.

One example I can give is the number of phone calls and concerns that we have been receiving about outpatient care. Many patients are participating in outpatient care because they understand it is going to be less expensive. What they found is that it is less expensive to medicare, but their costs increased individually. Outpatient care is not covered at the same rate as inpatient care.

So when you fix medicare, you also consider its relationship with private insurers, with medicaid, with the community care services and with both medical and nonmedical providers of the care.

I believe that my role in fixing this complex component of medicare is to channel information regarding changing population characteristics, et cetera, to policymakers to use in developing an appropriate program, and then, to feed back the program effects upon persons and systems locally.

For those purposes, then, I have the following observations. The first one is that we do support the concept of the DRG in that the system moves persons closer to the appropriate level of care. For years, aging offices have been in the business of developing community services, but have really had only small change to work with compared to the funds available to the health care system.

The burden on the limited community services system that we do have has increased greatly since the DRG program went into effect. One of our local Meals on Wheels programs has increased at an average of 50 meals a day just since October 1. They are now serving over 550 home-delivered meals in the Wichita area every day.

Moving patients from acute care hospitals to home-based community care does save medicare funds, primarily because medicare funds do not readily authorize home care. In Sedgwick County, the burden has been shifted from medicare funds to local property tax funds and charitably funded community services. The burden of physical care has also become tremendous on family care providers, most of whom are older women. Although the population over 65 comprises only 11 percent of the total population, the elderly purchase over 25 percent of all prescription medications. Most of these expenses are borne by the person out of pocket. We have had inquiries and requests for assistance from two-person families whose medicine bills exceed $150 a month.

We also believe that intense research is needed into the chronic illnesses associated with aging, such as arthritis, Alzheimer's, Parkinson's, and osteoporosis. We believe in finding a way to relieve the effects of the diseases or cure the disease, which will greatly bring down the cost of health care.

We feel there is a great need for greater linkage of health, medical, social, and informal support systems. The Administration on Aging has funded channeling demonstration projects, and those reports should be available within the next year. They should answer questions concerning the effects of a formal case manager system, which is a formal means of linking the resources available to the individual for their benefit. The importance of such a linkage mechanism cannot be overlooked. A patient can be sent home from the hospital and a home health nurse can be ordered, but if there is no other available family member to arrange transportation to the doctor, to provide groceries, to do the laundry, keep the person mentally active during the recuperation, pay the bills and explain and try to decipher medical billings, then, the bills and explain and try to decipher medical billings, then the quality of life or ability to stay at home is nearly impossible. These activities have not been the responsibility of the medical care program, but they are necessary elements in maintaining a person in their own home.

It is again an interrelationship among the many components of a community care system.

In conclusion, I urge a comprehensive review of the Federal health care policy, including not only medicare but medicaid. As our population increases, pressures on our currently fragmented system of care will cause it to break down. We need mechanisms for acute care, in-home care, and long-term, institutional care.

Factors in these mechanisms should include not only payment for medical care, but incentives for wellness and for family care, and also a recognition that the needs of a chronically or acutely ill older person are not strictly medical, but are also psychological and social meeting these psychological and social needs will assist in recuperation and in maintenance of well-being for the individual in their own home.

Thank you.

Senator KASSEBAUM. Thank you, Ms. Hart.

Before we take a break, I would like to have Mr. Wilson answer Ms. Mullikin's question regarding sharing among hospitals because I think it is one in which many of us have an interest. Is there a possibility that hospitals could share expensive equipment to a greater extent? In addition, what effect does the growing number of empty beds have, as far as transferring the cost to medicare, or who, in fact, absorbs that cost?

Mr. WILSON. Thank you. Well, I would respond to the equipment issue first. I think that if we are dealing with the CAT scanners—and perhaps Dr. Gleason would also like to speak to that—but for hospitals, such as the hospitals of Wichita, that provide a very intense service of secondary and tertiary levels of care, the CAT scanner, I think, is pretty well recognized throughout the country as pretty much state-of-the-art medicine and nothing but an important part of an arsenal of a hospital that provides those sophisticated services.

I think, however, we are seeing a sharing initiative coming about as the new generation of that type of equipment comes forth, the NMR, the nuclear magnetic resonators, which are very expensive and require a special type of facility, are being joint ventured. They are being joint ventured by the hospitals, radiology groups, and are being put on a free-standing site. So, I think that with the new generation of technology that is coming about, because of tremendous expense of these things, are being shared. So that is happening.

The excess bed issue, I think, poses another set of circumstances and I would like to really give you a scenario that is very real and actually happened to defend the hospitals a bit on how this has all come about.

I grew up in Iowa near Waterloo, which is the home of John Deere. And John Deere was kind of like the company store. They employed, I think, 17,000 people. So they had a very marked effect on services to the community.

And back when my dad was working for John Deere, they had a very, very broad, expansive health care benefits program. And that program did not have a lot of restrictions to it, and because of that, a lot of services that perhaps could have been handled on an outpatient basis, such as diagnostic services and some other services that could have been outpatient, were handled on an inpatient basis.

This was for convenience, for comfort, for a number of reasons. And the hospitals responded to that benefit package and increased the capacity of their facilities to accommodate the demand for those services.

John Deere, all of a sudden, realized that their health care benefits package was approaching $20 million and they said, we have got to review this; we have got to see if there is a better way of doing that. And so, they came up with the, probably one of the first, very broad private review programs. And they said, all right, we are going to restrict certain services to the outpatient setting. You can no longer be admitted for diagnostic services.

And what happened over a 3-year period of time is that the inpatient days went down about 15,000 to 18,000 per year, which meant in a 3-year period because of a change in posture by John Deere, the 45,000 fewer patient days were now in the system.

Now, this was good, but the hospital, in responding to the demand that had been there now found themselves with a great amount of excess capacity. But they were trying to satisfy the demand that the public was making for their services.

A number of things have happened all over the country that have basically placed the services in different sites, and much of it has been because of changes in practice that have been encouraged by the hospital's physicians to put that service in the least expensive site. The medicare program has become much more restrictive on what they will consider as an inpatient admission. And I think we will see with the new professional review organizations that are coming out, even a more restrictive approach because the acuteness of the illnesses is going to be very important, as far as what is going to be the criteria for determining an inpatient admission.

So, before there were review programs, patients stayed longer in the hospital as they were trying to solve a social need. Instead of

dismissing the patient on Thursday, they would wait until Friday and Saturday, or Sunday when it was more convenient for the patient to be discharged.

It was not immediately necessary; it was a matter of handling a social situation. And this is no longer practical, because of the cost of that service.

And so, there are a number of reasons; there was a demand. The demand was met. And now the system has shrunk and there is excess capacity.

Dr. GLEASON. I would almost say that physicians in the State would almost unanimously agree that the swing bed concept in small hospitals, especially in smaller areas, is extremely important because, if nothing else, the physician takes an extreme amount of problems related to the family in attempting to do what is appropriate in many of our small hospitals, which are under 50-percent occupancy in the State. And we do not have the nursing home capability.

So, I would say that this would be a very important aspect to really consider. I believe there are six hospitals in the State somewhere that are on the swing bed.

Mr. WILSON. I should have commented on that. I happen to be a member of the National Advisory Committee of the Robert Wood Johnson Foundation, sponsor of the swing bed project. There are six hospitals in the State involved with the swing bed project. However, we have a much larger number, I think, up to about 20 hospitals, that have been approved or are in the process of getting approved for the swing bed program. And there is legislation pending to increase the size of hospitals that would be eligible, and we support that legislation that would increase up to 150 beds, those hospitals that would be eligible.

I think that it has a significant impact on the smaller hospital. I think it is good practice in that it keeps that patient within the community.

It allows the attending physician to provide a full continuum of care, and it does give that patient the opportunity to stay close to friends and neighbors without having to be transferred.

Ms. MULLIKIN. Does that legislation include your urban hospitals, as well as rural? Currently, I understand it applies only to the rural.

Mr. WILSON. There is some movement just to promote 150 beds. However, I have to say that in talking to the Kansas delegation I have said that no bed limit should really be considered. The only question I bring out is when you get into the larger hospitals—and I think we see that at the capacity level we are at right now, it would be better for them to provide a distinct patient unit, different than a swing bed, and take a nursing unit and convert it to skilled or convert it to some type of stepdown care.

Ms. MULLIKIN. I am talking about the concept.

Mr. WILSON. The system as it determines the need for hospitalization—acute hospitalization, that is—has very certainly changed because convalescence has changed. This does need to be addressed, and I think the hospitals need to respond to that.

SENATOR KASSEBAUM. I think that we will take a brief break. I hope that when we come back, everyone will have thought of some very good questions.

If anyone in the audience would like to ask a question, you should write it on the sheets provided and submit it to me or to Susan Hattan of my staff during the break. At this time, I would also like to introduce Michelle Groves of the Social Security Administration office in Wichita. With her is Barbara Redding, who is a specialist in medicare and can answer any of the very technical questions you may have.

I think it is very nice of you to attend, because it is important for all of us to be able to draw on the resources that you can provide at the Social Security Administration.

I also believe that Judy Reno, president of the Kansas Association of Home Health Agencies, is here.

Thank you. We will take a 10-minute break.

[Whereupon a short recess was taken.]

Senator KASSEBAUM. I think that we will try to get back together. We have some very good questions that have been submitted from the audience. The television crew has asked that several of those who submitted questions ask them from the podium at the front of the room. I will also ask some of the questions handed to me.

We will take as many questions from the audience as time permits. Perhaps we can start with the gentleman who is doing graduate work at Wichita State University.

Mr. ALEXANDER. First of all, I would like to compliment Senator Kassebaum on this meeting and her continued work in this area. My question would be addressed to Marlon Dauner from Kansas Blue Cross/Blue Shield, and it pertains to addressing the justification of Kansas Blue Cross/Blue Shield in the refusal to allow transfer and payment to a local hospital—from a local hospital to a skilled nursing home of a terminally ill, elderly patient who had already surpassed their—quote, unquote—CAP payment allowances by several days at the hospital to the nursing home, despite the recommendation of the patient's physician for the transfer.

Mr. DAUNER. I am not familiar with the specific details of the case you are talking about, but there could be several issues involved. If the denial is made, it could be for one of several reasons.

There was a point made earlier about people being discharged from the hospital under a DRG system because there is an incentive for the hospital to get the patient out of the hospital. It may be that circumstances were such that the patient should not have been discharged from the hospital; on the other hand, it may have been another situation where the patient should have been discharged from the hospital; on the other hand, it may have been another situation where the patient should have been discharged from the hospital, but there are no benefits available to that individual under their benefit program for skilled nursing care.

In other words, their benefit program that they purchased through their health insurance did not cover skilled nursing care. And terminally ill people are not necessarily always, do not always have medical necessity for being in the hospital.

Mr. ALEXANDER. Apparently, that was the point of the physician's recommendation. Well, I guess that is as far as that should go, I guess. Thank you.

Senator KASSEBAUM. I have a question submitted by Leonard Moore. He asks: Do you feel that the Kennedy-Gephardt bill will work as a cost containment program; if not, why not? Will opening up medical schools for more admissions, thereby providing more doctors, increase competition and serve as a better control on overall health care costs?

Dr. Moon, can you answer the Kennedy-Gephardt question?

Dr. MOON. I would like to say something about the Kennedy-Gephardt bill. I think it is a very interesting bill, and I am glad it was mentioned in the hearing this morning. I think we should be aware, however, that the Kennedy-Gephardt bill is not an approach that would keep the medical care system exactly as it is today.

It would make some major changes in the health care system, particularly through hospitals and physicians. It would restrict choice, and it would lower reimbursements to hospitals. Those are approaches that we may decide to use, but to assume that changing reimbursements will not mean changes in the way that patients are treated, either by physicians or by hospitals, is to ignore some of the problems that hospitals and physicians will face.

In addition, this bill is interesting because it brings in all payers—rather than trying to reform the health care system by using individuals who are not the healthiest in our society, who are the most vulnerable in many cases. There are a lot of things to be said for health care reforms that are based on an all payer system for everyone. But, finally, I think that to assume that simply lowering reimbursements to physicians and hospitals over time will solve the problem ignores the fact that the American people are not ready at this point to give up the health care system they have. To a certain extent, you get what you pay for; there are some efficiencies that the bill would promote. But I think we should be careful to understand that it would change the nature of the health care system.

Senator KASSEBAUM. Dr. Gleason, did you want to answer?

Dr. GLEASON. Yes. I want to answer the other part of it. There is thought to be that there will be 70,000 more physicians than—excess physicians in 1990 and 140,000 in the year 2000.

What is basically happening is several things on this whole arena. First of all, we have an increase in medical schools from what we used to have and so they are, can put out considerably more physicians than they did. The size of classes has really increased.

I will give you an example; in Kansas when I graduated from the medical school about 23 years ago, we had 106 in my class. And last year they had 206. So that the medical school class in this State has almost doubled. The problem that is occurring is that the efficacy of good education for medical students is more difficult, especially with this new system where there is no educational pass-through; talk about not addressing a medical pass-through, so that the medical centers, such as the University of Kansas Medical School is going to have an extremely difficult time in finding

enough material and enough money to basically train other medical students.

And I must say this parenthetically—and it makes me somewhat sad in that we do not have as many students applying to medical school as we have in the past. It is down about 14 percent and the grade point average and the MEDCAT scores are down as well. Some of that is related to the problems within the system. Some is related, obviously, to the computer industry and things like that that are making a basic change.

And that is happening nationally. And there are six medical schools at the present time that have decreased the number of students that they have in each medical school class. And it is basically related to they do not have the material and do not feel it is important for them to have that many students. The Kansas Medical Society and the AMA basically have gotten into that argument and made no attempt to decrease the number of medical students in school right now.

To many physicians—and I am—if lawyers are any indication, too many physicians will not decrease medical costs, but may increase costs. So I am concerned about that. I do think that distribution basically is a very important aspect in the training of students in various areas and will allow them to get into those areas.

Where physicians take their residencies, where they get their formal training after medical school is directly related to where they practice, not to where they went to medical school.

Ms. MULLIKIN. I would like to tell the gentleman that in one of those hearings that was held before the Senate Aging Committee, there is a report on California where the number of physicians over a period of time, I think, almost doubled. And so did the cost. So that there was no correlation between number of physicians and reduced fees.

Senator KASSEBAUM. I would just like to follow up because, Mr. Dauner, you mentioned earlier that we lacked competition in Kansas and that this situation needed to be improved. Do you mean among doctors, hospitals? How should it be improved? What kind of competition do you mean?

Mr. DAUNER. Competition can be improved by bringing the entire health care system and the economic environment we operate in into a different framework, more like what we see in other segments of the economy. By that, people must be more informed, must have more information about these services.

I think DRG approaches are good from that standpoint. People can say, I am going to the hospital for an appendectomy and I can look at the price of an appendectomy among various providers of care, whether they be physicians or hospitals. Through those kinds of decisions, the public will become more responsible. The public has to assume some of the responsibility of selecting who they think are quality providers at a price they are willing to pay.

It is the same kind of a decision that is made in any other segment of our economy. That does not negate the fact that there are decisions made by providers of care in their rendering of those services and advising the patient. But still the patient is the ultimate consumer, has the ultimate responsibility for where those dollars go.

We have not allowed that to occur in the health care industry by the way we pay hospitals and physicians and the way that we write our benefit programs through third parties. And that needs to change and I believe that would bring different elements of the competition in.

Ms. MOORE. Senator, is it going to be possible for the consumer, the patient to have more input, a commitment of responsibility, to be made of people of all of the fields including the patient and consumers? Is there any opportunity, do you think, that the medical field would be interested in cooperating with us in that respect? Is there a way in which we as the patients can be more informed? It is very difficult to be informed when we do not know how and we do not have access except when we get the bill.

Mr. DAUNER. As far as Blue Cross/Blue Shield is concerned, and the medicare program I believe in the same category, data is being disseminated back to the individual who is consuming care, so that they know prices among the various providers. That is necessary information that relates to making wise decisions as a purchaser of the care.

As far as the medical society, the hospital association, cooperation in that activity, I think cooperation is going to be there because they have to respond to the fact that their patients are asking them to do something.

Ms. MOORE. Considering the time that it took Margaret Heckler to get anybody to sign whether or not they would take assignments, any of the doctors, I wonder if that is really going to work out.

Mr. DAUNER. I would maybe agree with that except I do not believe the physicians have been asked to take assignment other than on an individual claim basis, which I am not sure is a very appropriate way to look at assignments to begin with.

Ms. MOORE. It is impossible to get any information about it from the viewpoint of the patient.

Mr. DAUNER. Right.

Ms. MOORE. Unless you go down the list of every physician and call, until just recently, thanks to Margaret Heckler.

Senator KASSEBAUM. Dr. Gleason, do you think it could be improved?

Dr. GLEASON. I think it could be improved. I think one of the important aspects, as I talked about before, I have no problem with patient involvement because I have patient involvement in my practice all the time, and I have no problem in getting input.

I would hope—and I think that is appropriate—but I think also if we have appropriate input from everybody, and I think that is what we need, that we could come up with a solution where everybody has a say-so, rather than someone taking a position where there is no control; for example, the Federal Trade Commission becomes very much involved in our ability to handle cost because they will not allow us to do some things that might increase, because we cannot get involved in the process or we would be guilty of trying to have related fees. So that becomes a problem. So there are other agencies that become involved in the whole process. So I think physicians should have adequate input to the care.

Senator KASSEBAUM. From the consumers to the physicians.

Dr. GLEASON. I think that is very important.

Senator KASSEBAUM. Mr. Gerling, you submitted a question and said you would like to ask it. Please proceed.

Mr. GERLING. I think we had just better boil it down because priority is really the big problem. The priority is where we are going to get the money to take care of these necessities, and nobody has come up with any solution for that yet.

So we have to look at it as to what is going to come first. Is it going to come first that we build a fantastic defense or develop offensive weapons to protect us from some kind of a threat that we all hope never occurs?

At the same time, we are going to let people miss getting health care. Of course, I guess it is obvious that I am already in the borrowed timespan and that I will probably be needing more health care than I needed 50 or 60 years ago. So, we are going to have to come right down to it as to whether we are going to continue to finance offensive, totally destructive weapons of war or whether we are going to leave people unemployed. The remark was made here already today that, if we had full employment, we would have enough money to finance this.

Well, why in the world do we not have full employment? Do we not have enough work to do? We have to rebuild our highways. We have to rebuild our homes. I have information just here in Sedgwick County that, if we tried to put all of the houses that are presently used for living up to a minimum standard of livability and weatherization, it would keep all our unemployed here busy for the next 10 years. And so priority is the big question here.

The service should be available. I am an ex-member of a health maintenance group, and I think health maintenance is a big thing because there the doctors are paid on a monthly basis to take care of all of the needs that occur. I would very strongly recommend that for more consideration. Thank you.

Senator KASSEBAUM. Thank you.

Does anyone want to respond to the comments about the health maintenance organization in terms of its being an effective method of operation? There has been a lot of discussion about exactly how effective the HMO concept has been, and I do not know if anyone here wants to address that issue.

Dr. GLEASON. If I may talk to that because I think there are many different kinds of organizations going to work in certain parts of the country or certain areas. I do not think that probably one system is going to work everywhere.

For example, you take HMO's in the Minneapolis, Minn., area, which is probably one of the hot beds of HMO; just made a survey of the physicians involved in the HMO in Minneapolis and they found that only 26 percent of the patients were happy with the HMO in the Minneapolis area and that is a drop——

Senator KASSEBAUM. Why is that?

Dr. GLEASON. I will go into that. That's a drop of 47 percent 3 years ago to 26 percent at that time. First, they did not have the physician of their choice. Second, they did not feel that the appropriate tests were being run and they were not getting the same kind of medical care that they thought they were getting before.

And, third, they did not seem to be—they were seeing extenders many times rather than physicians. And these were the three major reasons for the drop of that. I think there are many other HMO's that we may be happy with. Again, it may be depending on that, but I thought this was an interesting situation coming from a hot bed in that area.

Dr. MOON. Could I just say briefly that I think when HMO's work well, when people are happy with them, they represent an alternative form of care that seems to work well and hold costs down.

But it is a system that I do not think you can impose on people. I think people have to be willing to participate. As Dr. Gleason mentioned, there are also other alternatives now being developed where physicians are getting together and developing systems comparable to HMO's in which physicians are the case managers; those types of alternatives represent important long-term approaches that should be seriously considered.

Senator KASSEBAUM. I think perhaps somebody ought to explain what HMO's are.

Dr. MOON. Under a health maintenance organization, an individual pays a set amount for all of the health care that he or she needs.

Physicians generally work for the HMO and hospitals contract with or are owned by the health maintenance organization.

Individuals know ahead of time exactly how much they will pay for health care, and the organization then has to find a way to delivery health care services within that budget.

Ms. MOORE. We find in our experience that most of these HMO's refuse to take persons who are on medicare, unfortunately. So it is really not anything that we can effect here.

Dr. GLEASON. I think the figure is 5 percent medicare, I think, nationally, somewhere.

Ms. MULLIKIN. Yes, I think where HMO's may be part of the solution in the future is that workers who currently go to an HMO then are covered in old age or after they become eligible for medicare, so that it is very true, their medicare, their older population enrollment is very low, but on the other hand, I do not think an HMO would have much justification for kicking out members just simply because they become 65 years of age.

And so it may very well be one of the solutions that would help in the future.

Senator KASSEBAUM. Thank you. Margaret Bangs has a question she wants to ask. It is long and written out.

Ms. BANGS. I am windy and I have to write them out. This is my first year as a medicare enrollee and understandably, I guess, that I am not very knowledgeable. And, therefore, I find it confusing that when Congress talks about raising money to cut $200 billion deficits, social security and medicare are often targeted as areas for cutting the deficit.

And yet Dr. Feldstein, Reagan's chief economic adviser, has said that these programs have no effect on the deficit as they were funded by payroll taxes and payment by the medicare beneficiaries; instead, deficits had been caused primarily by increased military spending and the 1981 tax cut. So says Dr. Feldstein.

Last week the U.S. Senate passed a bill to raise $45 billion additional to cut the deficit. Included was a Senate approval for $14.8 billion in spending cuts, primarily for medicare. Monthly premium payments for full physician care would be increased to $26.70 a month by 1989 from the current $14.60 a month.

Perhaps I misunderstood, Dr. Moon, that in 1984 taxpayers would pay $1,754 a year for each participant in medicare. I had thought that medicare was not funded by general revenues. You see, I have so much to learn.

Senator KASSEBAUM. I would like to make a brief clarification. The tax bill that we passed last week did not include the increase in the part B premium. That provision will be discussed next week as part of the spending side of the debate. So we have not passed that increase yet.

Ms. BANGS. Well, then the Wall Street Journal is in error.

Senator KASSEBAUM. It is surprising to be able to say they are in error. But indeed, that is true. Proposals dealing with the part B premium are part of the administration's budget, but they were not part of the revenue provisions that we voted on last week. The Senate will consider an increase in the part B premium next week.

Ms. BANGS. I see. But it is part of this whole effort to cut the deficit.

Senator KASSEBAUM. Yes, it is. I know you addressed your question to Dr. Moon, but let me just say that 75 percent of part B benefits are financed from general funds revenue.

Ms. BANGS. See, I did not know that. OK.

Dr. MOON. The $1,750 figure that I used includes income from general revenues and payroll taxes. We fund social security and medicare through what we call an unfunded system. It is a system in which individuals who pay taxes now are paying for current retirees. My payments into social security do not go into a little account with my name on it. There is a little account under my name, but there are not any funds in it. I am waiting to see whose children will pay for my social security and medicare when I retire.

So, from that standpoint, it is taxpayer supported. From the standpoint that it is a promise of future generations of workers to pay for current future generations of workers, there is a commitment that makes it different from other kinds of revenues. I think what Martin Feldstein was referring to is the fact that at this point, there is not yet a deficit in the HI trust fund.

What we are facing in the future is that those taxes are not going to be high enough to support the program. But that has not occurred yet. If it were to occur and nothing was done to solve that problem, I think that general revenues would be used. But technically speaking, under the law there simply would not be payment of medicare benefits if the fund became depleted.

Ms. BANGS. Thank you. I am enlightened.

Senator KASSEBAUM. Thank you. Well, I think everybody, including those of us in the House and Senate, get very confused about all of this. I want to explain one term we used—part B. I do not know whether everybody realizes that this portion of the program covers physician and certain outpatient services. Part A is hospital insurance. So, medicare is divided into two parts. Part A benefits are paid entirely by the trust fund to which payroll contributions

are made. Part B, however, does not receive trust fund moneys. Rather, it is financed by premiums and the general fund.

As confusing as it is to follow congressional actions, it is even more difficult to figure out how we deal with entitlement programs. Nearly everyone indicates they have contributed to their entitlements—meaning programs such as railroad retirement, social security, medicare, or black lung disease. Thus, they believe they are getting back out only what they have paid in, with interest accrued. That way, entitlements are not seen as something that is adding to our overall budget deficit.

The problem is, we are taking in less than is going out in many cases. Now, social security will be moved off-budget beginning in fiscal year 1992.

Ms. MOORE. Nancy, you probably know that it was not in the Federal budget until 1969 during the Vietnam war when they wanted——

Senator KASSEBAUM. Of course, this is it; current budget conditions have a lot to do with whether or not we want to move things off-budget. I am one who believes that, if we really want to evaluate the health of our budget in its entirety, it is best to have everything on-budget. When there are deficits, there is a cost of borrowing at some point whether those deficits are on-budget or off-budget.

I also think it helps us to better understand the different programs if they are on-budget. Nevertheless, social security will be moved off. There are some who believe all of the trust funds, including the highway trust fund and the aviation trust fund, should be moved off-budget. I am sure that issue will be a growing portion of the debate.

Ms. MULLIKIN. Incidentally, is that $1,754 a year cost, does that include medicaid or is that medicare?

Dr. MOON. That is just medicare.

Senator KASSEBAUM. I was given a question which I thought was rather interesting. I know you have to leave, Margaret, but let me ask you this because it is regarding swing beds. The first part of the question asks to please clarify the phrase "swing bed arrangement." I would agree sometimes we talk about these terms as if everybody knows them and it gets confusing.

The second part of the question is: When a person is transferred in a hospital to a swing bed, is there a reduction in cost similar to nursing home patient care costs?

Ms. MULLIKIN. I would yield to someone who is familiar with how that concept gets practiced.

Mr. WILSON. I will take care of that. Swing bed programs started out several years ago as a pilot program. What it basically does is it takes and transfers the patient within the acute facility. Once that acute patient's illness is over, but yet the patient needs perhaps more rehabilitative services, for example, they can be stepped down; for example, from acute to skilled to intermediate. At the skilled level the patient rate is determined by the average of the State medicaid rate and, with a few exceptions, that rate is pretty well addressed by legislation. The intermediate level, for the most part, is private pay and that is set at what would be primarily a nursing home level of payment.

So the payment is stepped down, and it is basically two levels of care, either skilled or intermediate.

Mr. BAKER. How many in Wichita have the swing beds?

Mr. WILSON. None of the hospitals in Wichita are eligible. The law only will allow hospitals with less than 50 beds to participate in the program at the present time.

Mr. BAKER. None in Wichita.

Mr. WILSON. Some of the hospitals in Wichita may have distinct long-term care units, and that is different. That is where you take a 30-bed unit and it is all dedicated to one level of care. What we are talking about is a 30-bed hospital may dedicate 5 or 6 of its beds to be used for skilled or intermediate care. You may keep the patient in the same bed. You are just stepping down that patient's level of care.

Ms. HART. I have a question. Our limited experience with the DRG's has shown a reduction in medicare expenditures in hospitals. I understand the Health Care Financing Administration will have a report in the next year on nursing homes and home health care.

Do you anticipate any kind of a similar medicare reduction through prospective payments for those two kinds of services?

Senator KASSEBAUM. Certainly, I think a lot is going to depend on the analysis of how prospective payment works in the hospitals. The same is true with respect to any move we may make toward extending prospective reimbursement or the DRG concept to physician payments, which is also under review. A number of factors will have to be considered in evaluating this new system. As Ms. Mullikin pointed out earlier regarding DRG's, one of the important questions to be addressed is whether real savings will be achieved with DRG's or whether, in fact, costs will merely be shifted elsewhere. This aspect will be closely monitored and analyzed, and the findings of this evaluation will have a great bearing on our determinations regarding the expansion of prospective payment to include physicians, nursing homes, or other health care providers.

Mr. WILSON. Our early asessment of PPS is taken from hospitals that started the program on October 1. There was not a large number, but for that group of hospitals, admissions were down 7.9 percent; patient days down 22 percent. We do not know whether that can all be attributed to the prospective payment program.

Ms. MOORE. In looking over the recommendations to the medicare advisory council, I find under eligibility, No. 3 says individuals

should no longer receive medicare on the basis of a medical diagnosis. For crying out loud, what diagnosis do they use if not the medical?

Senator KASSEBAUM. Does anyone wish to respond?

VOICE FROM THE AUDIENCE. Who wrote that? The girls in the office?

Senator KASSEBAUM. Then, obviously, it is a good question that someone should examine. We will take it under consideration.

Ms. MOORE. I hope.

Senator KASSEBAUM. I want to ask a couple of brief questions, and I know that we do not want to run too much longer. Dr. Moon, in your testimony, you noted that older persons spend about $1,000 per year for health expenses out of their own pocket. And, Mr. Smiley, in your testimony, you noted also that there is some confusion about actually what medicare covers. I wondered what kind of health care costs the elderly are paying out-of-pocket. Do you have some idea?

Dr. MOON. I do not have all of the figures in front of me. Certainly, one of the most improtant components is nursing home care. Not very many people pay, but when they do, it is a great deal. There are also a large number of deductibles and coinsurance that individuals are asked to contribute through the medicare system itself; that is, individuals pay physician and hospital care costs in the range of $400 a year.

The $1,000 figure also includes a contribution for insurance under part B of medicare that the individual pays and an average cost for individuals who purchase private insurance to supplement medicare.

Finally, drugs are also an important out of pocket expense for the elderly.

Senator KASSEBAUM. I would like to turn to a couple of the future options that have been mentioned and ask all of you to ponder them.

Mr. Wilson talked about the need to have long-term solutions. I think we would all agree that none of the choices we face in devising long-term solutions are very appealing. They are, all of them, politically difficult. The problems facing medicare are, of course, a deep worry for those who are on retirement incomes. If we are to develop fair and appropriate solutions, we must all take a serious interest in these issues and become better informed about them. That way, we will be able to work together coming up with good answers. That was really the intent of this hearing.

I know one of the TV commentators said he was a little disappointed there had not been more confrontation. Maybe they wanted you to jump up and hit somebody over the head.

Ms. MOORE. I failed miserably.

Senator KASSEBAUM. I think the purpose is to share information about an issue which is really a great concern to all of us. One of the future options recommended by the Advisory Council on Social Security is that the age of eligibility for medicare benefits be raised from 65 to 67. The Advisory Council argues this is a good approach because life expectancies continue to increase.

I would guess that if I asked how many of you here thought that was a good idea, there would not be many who would support it. How many think that would be a good idea? How many not?

Well, it is fairly well divided.

Ms. HART. One of the most frequent calls we have through our information and assistance division is regarding health insurance for people age 60 to 65, people who retire early, widows and disabled persons who are finding insurance costs to be prohibitively expensive.

Some of them can quote figures of $400 a month for health care insurance. If raising the medicare eligibility age would extend that vulnerable age group another 2 years, I would not be in favor of it at all.

Mr. DAUNER. As another point, most insurance companies are moving to what we call age rating and the people who are in the higher age bracket are rated according to the risk that is associated with their levels of utilization; it is obviously going to be higher. Their rate is higher. And a $400 a month premium is probably not unreasonable in some situations.

Ms. MOORE. Except if your income is $200, you are kind of up the creek without a paddle.

Senator KASSEBAUM. Right now everyone over the age of 65 who is eligible for social security is automatically eligible for medicare benefits, no matter how high their income is. There have been recommendations made, as some mentioned here this morning, that we should consider means testing this program. By that, I mean those above a certain level of income would pay more for their health benefits, rather than everybody receiving the same benefits. I think the idea of applying a means test is one that is going to be raised concerning all of the entitlement programs.

How many of you here on this panel think that medicare should be means tested? How many not?

Ms. MOORE. May I?

Senator KASSEBAUM. Please.

Ms. MOORE. I find it very distressing. We have been told to provide for our own old age. Many people have done so. They have struggled and done without all of their lives so that when they retire they would not be dependent on someone else. Now I find they are being penalized.

Voice from the audience. That is correct.

Dr. MOON. I think that is a very good point. I am in favor of means testing in some very restrictive way, in which if we are going to increase the cost on current enrollees and there is no way around it, I would like to see us do it on the basis of income. I would not like to see means testing used to deny basic benefits to the elderly and the disabled because one of the important aspects of medicare and its acceptance is that it is a universal program and I believe that is important.

Mr. WILSON. There are a couple of things that need to be considered when you talk about means tests, and it is obvious there is a certain group over age 65 that have incomes that are exceedingly large. And there could be a broader program put together that would at least extend the means testing perhaps very quickly to

that group. If a person has an income of $200,000 or $300,000 a year, the medicare program is perhaps of little need to that group.

On the other side, what I talked about when I talked about the long term solution and I look at my future. I would like to see some type of broad, long term strategy put together so that I know when I get to be age 65 or whatever age that is, that I can expect to have maybe 50 percent or 40 percent funded. I do not think it is fair right now to get into a very strict type of a program, but I think something at a higher level, but then some type of a process that would phase in means testing might be appropriate.

Senator KASSEBAUM. One of the other options for the future is the idea of creating incentives throughout the health care system. Mr. Smiley mentioned such incentives early in his testimony, and several other suggestions along this line have also been made today.

To sum things up, it is clear that there are some difficult questions that lie ahead. At the same time, as we have seen today, there are also a number of options available to us in resolving the problems we anticipate. We are fortunate to be able to analyze and debate these options before we are faced with a real crisis. I think that is important, as crisis situations rarely lend themselves to thoughtful and well-reasoned solutions.

It is also essential that we work toward a better understanding with one another. Each of us approach the medicare system from our own point of view and our own set of priorities. It is only by exchanging ideas with others that we can appreciate the full range of factors which must be taken into consideration. Moreover, as we look at medicare, we begin to recognize the interrelationships among medicare, medicaid, long-term care, home health care, and—indeed—the health care system in its entirety. To make truly informed choices, we must realize that any proposed change in medicare will have ramifications for other aspects of our system.

So, a better sharing of information and a fuller understanding of the options before us would serve us all well. Everyone is affected in some way.

I very much appreciate all who have served on the panel this morning, giving your time to try and help us understand some of the difficult choices that lie ahead. Thank you very much.

[Whereupon, at 11:48 a.m., the committee was adjourned.]

APPENDIX

MATERIAL RELATED TO HEARING

ITEM 1. STATEMENT OF JUDITH RENO, R.N., C.N.A., PRESIDENT, KANSAS ASSOCIATION OF HOME HEALTH AGENCIES

In the preamble of the 1965 law that enacted medicare, Congress wrote three basic points:

(1) That health care is the right for all older Americans.

(2) That older persons are sick three times as often, hospitalized three times as long and with health care costs approaching four times the cost paid by younger adults.

(3) That it was the finding of Congress that there should be no variation in the quality of health care services because of the patient's ability to pay.

The frail elderly are a significant group in society today and their needs are not being met. Often undernourished, confused and alone, they are afraid to seek or use services, concerned that their small savings or incomes will be used up or they will be sent to nursing homes.

Home health care is a viable option that has recently come into its own. With the advent of DRG's, home health agencies are expanding at a phenomenal pace. Since 1979, in Sedgwick County, there has been a growth of the total number of medicare certified agencies from one to a present total of eight. My own agency has grown from 150 patients per month in 1980 to over 600 patients in March 1984. It is estimated there are currently more than 17,000 home care providers. More than 4,000 agencies are medicare-certified home care providers. We are seeing many types of agencies and services from one or two service providers to large multiservice agencies. Some agencies are proprietary (for profit); some are private nonprofit; some voluntary nonprofit; some are extensions of hospital services and others are located in local health departments. There are national home care chains. Owners of home health agencies include physicians, nurses, businessmen and drug companies. This diversity creates competition and fosters cost effectiveness but it also runs the risk of creating substandard care.

Medicare costs rose an average of 19 percent for the years 1979, 1980 and 1981. Health care costs are approximately 10.6 percent GNP. In 1979, HCFA estimated 30 home health patients for every 1,000 medicare patients. Reflecting on recent experiences, this number has probably increased to an estimated 120.

The pendulum swings. Not more than 50 years ago, people remained in their homes for their health care. They only went to the hospital to die. Once again, persons are choosing to remain at home for their health care and often even to die (hospice). Home health care and hospice are viable options to the high cost health care that medicare has purchased in the past.

Attached is a position paper on long-term care in Kansas prepared by the Kansas Association of Local Health Departments and the Kansas Association of Home Health Agencies. Though written for Kansas, it is applicable to the Nation.

POSITION PAPER ON LONG-TERM CARE IN KANSAS, BY THE KANSAS ASSOCIATION OF LOCAL HEALTH DEPARTMENTS AND THE KANSAS ASSOCIATION OF HOME HEALTH AGENCIES

BACKGROUND

As people grow older, the probability increases that they will experience acute and/or chronic/degenerative health problems which require care and treatment, and which impinge on their ability to carry out routine activities such as cooking, personal grooming, and housekeeping. In the absence of services to help these people in their home, many elderly have entered nursing homes even though they

were not in need of intensive or semi-intensive medical assistance. In Kansas, 7 percent of all persons 65 and older reside in nursing homes; nationaliy the figure is 5 percent. Whereas a number of these individuals are best served in a nursing home, studies indicate that a minimum of 10 percent and a maximum of 40 percent could reside in the home setting if a variety of long-term care support services were available.

The provision of an array or "continuum" of long-term care services (health, mental, social, and general support in nature), delivered by a wide variety of providers (professionals, paraprofessionals, families, friends, and volunteers), and made available in a number of sites (home, community agencies, institutions, and other residences), is the desired goal in Kansas. As the model on the following page illustrates, there are over 50 services included in the long-term care continuum. The model also provides information on the number of programs or the number of counties served by formally organized programs in Kansas; it is not possible to adequately reflect the important role played by families and friends who informally provide services. A further point to note about the chart is that although we usually think of long-term care services for the elderly, there are other population groups (the developmentally disabled and the chronically mentally ill) who may also require long-term care services.

Although there are a number of quality long-term care services in Kansas, examination of the chart clearly indicates two specific problems. First, service gaps exist. There are 105 Kansas counties, yet few services, with the exception of intermediate nursing home care, appear to be available in that number of sites. Second, a coordinating mechanism is needed to assist the elderly and their families and friends in identifying needed services and arranging for agency contacts and service delivery.

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Formally Organized Long-Term Care Services in Kansas

306,263 Elderly; 19,410 Developmentally Disabled; 3,648 Chronically Mentally Ill

Event Generates Need

Home

- Home Health - 69 Counties
- Homemaker - 385 Coverage (serve approximately 8,000 persons 60 and older per month)
- Meal Program - 334 Home-delivered Meal Programs in 91 counties
- Chore/Home Repair - 8 Known; Statewide Weatherization Program
- Hospice - 22 Programs
- Telephone/Visitor Reassurance - 4 Known
- Companions - 3 Known
- Shopping Assistance - 1 Known
- Escort Services - Unknown

Community Agency

- Day Care - 17 Programs
- Transportation - 93 Counties
- Meal Program - 240 Congregate Sites in 88 Counties
- Senior Center - 123 Sites
- Senior Health Clinic - 74 Counties
- Public Health Nursing - 97 Counties
- Mental Health Center - 35 Centers
- Retirement Counseling - Major Companies
- Job Counseling and Employment Programs - 1981 Legislative Bill
- Foster Grandparents - 10 Programs

Specialized Site

- Foster/Family Care - 888 Assessment
- Respite Care - Several nursing homes will provide
- Alternative and Transitional Living Supports
  - Congregate and Retirement Communities - 12 Known
  - Shared Housing - Unknown
  - Supervised and Group Living Title XX Homes - 731 Beds Retardation; 144 Beds Mental

Institution

Small Facilities

- Personal Care - 386 Beds; 8 Counties
- Specialized 15-Bed or Less - 119 Beds; 6 Counties

Large Facilities

- Intermediate/Retardation - 1,003 Beds; 11 Counties
- Intermediate/Mentally Ill - 434 Beds; 6 Counties
- Intermediate - 26,887 Beds; 105 Counties
- Skilled - 3,314 Beds; 34 Counties

Hospitals

- Acute - 13,620 Beds; 96 Counties
- Specialized - 1,373 Beds Mental; 1,501 Beds Retardation

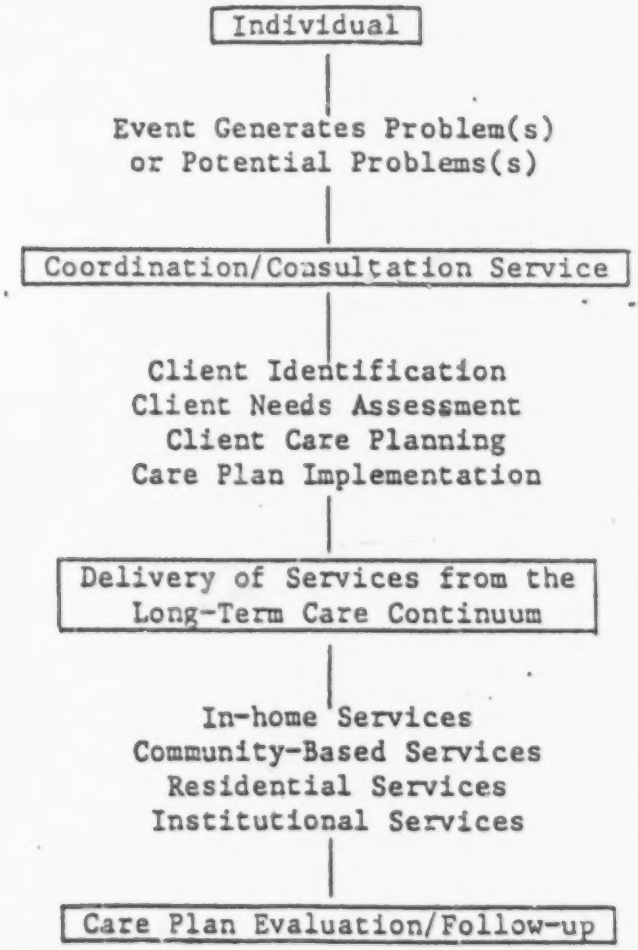
All Settings

- Income Maintenance - Social Security, Private Pension, Supplemental Security Income, etc.
- Financial Management - Unknown
- Aid to Families with Dependent Parents - None
- Emergency Loans - Unknown
- Information and Referral - United Way, Area Agencies on Aging
- Crisis Intervention - Mental Health Centers
- Hot Line - Department on Aging
- Disaster Relief - Energy Assistance Programs
- Recreation/Talking Books - Local Libraries, Parks and Recreation Departments, etc.
- Advocacy/Ombudsman - Department on Aging, Area Agencies on Aging
- Legal Aid - 3 Known
- Protective Services - Department of Social and Rehabilitation Services
- Education - Discount Tuition or Special Programs at Some Schools, Universities, and Colleges
- Support Groups - Unknown

Sources: Bureau of Community Services and Office of Health Facilities, Kansas Department of Health and Environment; Medical Services Section, Kansas Department of Social and Rehabilitation Services; Kansas Department on Aging; Kansas Department of Transportation; Kansas health systems agencies; and newspapers throughout the state.

DESIRED LONG-TERM CARE SYSTEM

When an older person experiences a problem(s), or the potential exists for a problem(s) to develop, they should first have access to a coordination or consultation service (sometimes referred to as case management). This service should be professionally designed to help the older person assess their problems, explore service options, develop a service care plan, and arrange for service delivery. The following chart illustrates the ideal flow and potential outcomes of the system.



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IMPLEMENTING THE DESIRED SYSTEM

The basic question to be addressed is how public and private agencies in Kansas can combine efforts to accomplish service coordination/consultation, service delivery, and individual foliowup. At the present time, a number of efforts are underway in Kansas:

The Department of Social and Rehabilitation Services conducts a preadmission screening (PAS) program to assess the need for nursing home services among the medicaid elderly. When a nurse and social worker team determine that nursing home care is medically necessary, the client is evaluated for placement in the home and community based services (HCBS) program.[1]

The Department of Health and Environment is working with four local health departments to implement the LIVELY (life, interest, and vigor entering later years) program. The goals of this program include community service coordination for all elderly in the area and development of local community task forces to address aging-related problems in the area.

The Kansas Legislature has assumed responsibility for development of some long-term care services. Since 1978, the legislature has provided over $1 million in aid-to-county funds to start home health agencies in unserved areas, and over $100,000 to the Department on Aging for adult day care programs.

Local communities are expressing their commitment to long-term care service development. Sixty counties now have mill levies for aging services. There are also examples of aging organizations and community residents in Riley and Shawnee counties joining forces to explore case management systems.

These developments have been extremely valuable because they have added to the knowledge base about Kansas elderly and the long-term care system. The various efforts also, however, cause problems when looking at ways to implement the desired system. The brief review of current programs clearly indicates that efforts to improve the Kansas long-term care system are fragmented. There is a lack of coordination between State government agencies, and between the government and local communities. One result is that efforts to screen for service needs occurs too late (after nursing home placement) for some individuals. Once a placement has been made, it can be traumatic for an individual if further changes are imposed. Programs also differ in their coverage of the population, when the desired goal is to improve the system available to all elderly.

PROPOSAL FOR THE FUTURE

Because the goal of the long-term care system is to help Kansas' elderly live as independently and normally as possible, system improvements must be initiated where the elderly reside: in their home community. Virtually, every Kansas community is served by at least a few formally organized long-term care services. In addition, many communities have unique strengths available through informal (family, friend, and volunteer) support services. In the future, the long-term care system must make every effort to build upon existing resources. In this endeavor, it will be important for communities to organize task forces of service providers, the elderly, and other community residents to evaluate the strengths and weakness of their current long-term care system and develop plans for service changes.

The State government has an important role to play in the development of a community-based long-term care system. First, the Departments of Health and Environment, Social and Rehabilitation Services, and Aging have monitored current efforts and have developed staff expertise which can be technical assistance in community organization. A working structure which would help coordinate State government activities is in place in the form of the Governor's cabinet subcommittee on long-term care. This group should be charged with the responsibility to develop a combined State plan.

Second, the Department of Social and Rehabilitation Services is vitally involved in purchasing services for older persons with limited incomes. Although some services are currently organized by the department (e.g., homemaker services, nonmedical attendant care, and case management), as local organizations develop and/or enhance their service resources, the department should contract with the community to provide the services. To assure adequate and appropriate use of contractual services, guidelines would have to be developed clarifying each party's role. Elderly per-

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[1] HCBS is a medicaid waiver program which provides reimbursement for a variety of noninstitutional services not normally covered by medicaid.

sons with financial resources should be able to purchase services in accordance with their level of income.

Third, the State government should continue to provide money for initial development of important long-term care services. Although a major concern in the field of long-term care is how to provide service coordination, this is of little value if a variety of services to meet an individual's needs are not available. Knowledge gained from current programs indicates major gaps in the areas of homemaker/home health aides, day care, alternative housing like adult family homes, respite care for clients and families, hospice, meal programs, and wellness checkups.

Related to this issue, there must also be adequate funding/reimbursement for the services once they are developed. Currently, a number of gaps exists. State government officials and community providers should jointly review problem areas and develop a plan of correction.

Because implementation of the desired community-based system will take some time, there are a number of short-term corrective actions which are needed, given current problems within the system.

First, when screening to determine the need for nursing home care occurs, it must be timely. That is, it must occur prior to institutionalization, and prior to the time the elderly and his/her family have exhausted physical, emotional, and financial resources. In part, this will be assured if there are greater numbers of screening/assessment entry points. These points should include nursing homes, hospitals, and community service organizations; the service points should be accessible to all elderly, regardless of income.

Second, screening to determine service needs must be standardized and evenly applied, but also must be sensitive to the individuals involved. A shortened screening tool could be of value in many cases where multiple problems are clearly evident and immediate action is required. Further, personnel administering the assessment tool must be professional and exercise good judgment or discretion in use of the tool. Questions which have been shown to cause unnecessary anxiety should not be routinely applied. In the short-term, it would be valuable for local community workers, State agency staffs, and university personnel to convene a meeting and exchange ideas on how adaptations might be made.

Third, as a transition between the current and desired long-term care system occurs, there must be greater use of existing, certified community service agencies. This will serve to involve the community from the beginning in the change process. The use of certified agencies also helps to assure that a high quality of care is provided. Further, it provides a new level of accountability for service delivery to both the community and State reimbursement agencies.

Finally, the current system can place greater emphasis on care plan evaluation and followup. Within the HCBS Program, this could occur through routine wellness monitoring checkups. Within the LIVELY program, this could occur through the case management system. The importance of reevaulation cannot be stressed enough. It is not possible to develop care plans with complete accuracy given unanticipated changes which can occur in an individual's health status, environmental supports. financial resources, etc. At a minimum, some contact should be made with individuals receiving services every 30 days.

CONCLUSION

The alternative of taking no action to improve the current long-term care system is not acceptable. First, over $66 billion are spent nationwide on formal long-term care health services. This is in excess of $2,615 per older person. Further, the value of services provided informally by family and friends is estimated at $50 billion. Because of the dramatic increases taking place in the size and proportion of the elderly population,[2] there is little possibility that total long-term care expenditures will be reduced. However, it is possible to ensure that future dollars are spent as effectively as possible, on as wide a range of services as possible.

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[2] In 1900, 4 percent of the population was age 65 or older. By 1980, this equaled 13 percent in Kansas. By the mid-21st century, the proportion of elderly will equal 18 to 25 percent.

ITEM 2. STATEMENT OF MORTON EWING, HUTCHINSON, KS; FLOYD POPE, WICHITA, KS; AND KATHERN FOREST, WICHITA, KS; REPRESENTING THE AMERICAN ASSOCIATION OF RETIRED PERSONS

We are Morton Ewing, Hutchinson, Kans.; Floyd Pope, Wichita, Kans.; and Kathern Forest, Wichita, Kans., speaking as representatives of the 200,000 American Association of Retired Persons (AARP) in Kansas.

The rapid escalation in health care costs in general and hospital costs in particular has been driving up the costs of medicare. Along with the the shortfall in the HI trust fund, expenditures are also rapidly rising in the supplemental medical insurance fund (part B). Because three-fourths of part B is financed by general revenues, it is not in danger of bankruptcy. However, to meet projected demands, the share of general revenue necessary to finance the SMI trust fund will have to rise from 3.1 to 5.7 percent between 1982 and 1988. According to the CBO, if the share of general revenue contributed to SMI trust funds were not allowed to rise, expenditures would have to be reduced or premiums increased by almost $2.7 billion over the 1984 to 1988 period.

Over the past 3 years, Congress has enacted medicare cuts totaling billions of dollars through 1986 in an attempt to reduce medicare's burden. Achieving budget savings solely within the parameters of medicare, however, has little long run impact on the escalation of medicare costs. Other restraints are needed.

Here listed are brief statements of AARP recommendations for health care cost containment:

(1) AARP advocates mandating limits on the rate of increase in payments to providers, especially hospitals. This should be done in order to slow the excessive rate of growth in health care costs that will bankrupt medicare.

(2) Mandated limits should apply to all third-party payers, including private health insurers. Placing limits solely on medicare encourages providers to shift costs to other payers and does not curb health care costs for the Nation as a whole.

(3) States should be encouraged or required to establish mandatory hospital rate review programs. Six States with such programs have had success in limiting hospital cost escalation. In 1983, these States held their hospital cost increases down to 10.8 percent compared to 16.3 percent for all other States.

(4) Capital expenditures for new building and equipment should be controlled so that new medical facilities add only essential services. Expansion promotes higher charges because facilities must cover their increased operation costs.

(5) Caps on payments to providers are necessary in the short term to "free up" resources for less costly and more appropriate alternatives to institutional care. Over the long term, AARP believes that regulation should gradually give way to more market oriented solutions which promote competing forms of health care delivery such as HMO's, small clinics, etc.

On the other hand, we strongly oppose such proposals as listed below:

(1) The burden of medicare costs should not be shifted to beneficiaries through benefit cuts, such as increasing deductibles and coinsurance or raising the eligibility age to 67. The elderly already spend 15 percent of their income on health care and many would lose access to care if they had to pay more for their services.

(2) Medicare's costs should not be shifted to workers by increasing taxes. Social security payroll taxes are already too high and are burdensome for lower income families.

(3) Rising medicare costs should not be shifted to higher-income beneficiaries through means testing. This approach would convert medicare to a welfare program.

We feel that these three options would merely shift rising health care costs to beneficiaries or workers rather than control those costs.

AARP advocates a comprehensive approach to health care costs which focuses on negotiating, or, if necessary, mandating limits on the rate of increase in payments to provides, especially hospitals; for all third-party payers (private and public), not just medicare. Our proposals strongly encourage the adoption of mandatory rate review programs. In addition, we support restrictions on physician's fees. The association realizes that capping the rate of increase in provider payments represents a regulatory approach to health care reform. Nevertheless, the AARP believes that this approach is necessary in the short term to slow the rate of growth in health care costs and to prevent insolvency in the HI trust fund. Over the long run, AARP believes that regulation should gradually give way to more market-oriented solutions. Additionally, we support the greater use of ancillary health care personnel, especially in underserved rural and inner-city areas and such neglected institutional setting as nursing homes.

AARP believes that medicare is in financial trouble because of rapidly rising health care costs, particularly hospital costs, not because the elderly do not pay enough for their own health care.

ITEM 3. LETTER AND ENCLOSURE FROM DEAN B. EDSON, TOPEKA, KS, EXECUTIVE DIRECTOR, KANSAS ASSOCIATION OF HOMES FOR THE AGING; TO SENATOR NANCY LANDON KASSEBAUM, DATED APRIL 20, 1984

DEAR SENATOR KASSEBAUM: We regret, due to other scheduling problems, we were not able to attend your hearing in Wichita today regarding the medicare program.

I have taken the liberty of sending you comments from one of our members. John Grace, executive director of Meadowlark Hills in Manhattan, Kans., is a very knowledgeable individual and one of the 12 facilities in Kansas who participates in the Federal medicare program.

Hopefully, John's comments will give you some idea of the problems encountered by those who participate in the program. Please feel free to contact us if you need further comments or clarification.

Sincerely,

DEAN B. EDSON.

Enclosure.

STATEMENT OF JOHN GRACE, EXECUTIVE DIRECTOR, MEADOWLARK HILLS, MANHATTAN, KANS.

Meadowlark Hills is a not-for-profit retirement community consisting of 97 independent living units and 53-bed skilled nursing center.

Our facility opened in the fall of 1979 and began participating in the Federal medicare program for institutional skilled nursing care in October 1982. Since that time, we have served approximately 35 separate individuals in our skilled nursing center who have benefited from the Federal medicare program.

The benefit of the medicare program in a skilled nursing care center is that it does relieve some of the financial burden upon the individual who is suffering from acute illness for a short period of time.

The failings of the program are as follows:

(1) A limited number of facilities participate in the Federal medicare program. In Kansas, there are only 12 facilities in the State that participate in the Federal medicare program. Why? Mainly because the excessive Federal requirements and cost reporting information required makes it too burdensome on the facility to meet these requirements. These are not requirements that insure "quality of care," but requirements that insure the facility's cost as reported is legitimate. As a result, the older person in Kansas has limited choices available as to where they can receive their medicare benefits for skilled nursing care.

(2) Skilled nursing care is defined as too restrictive. Because of the Federal Government plan to reduce their payments for these programs, the intermediary, such as Blue Cross/Blue Shield, is very stringent on qualifying a person for skilled nursing care. If the person does not fit into one of the pigeon holes as defined by Federal law as needing skilled nursing care, then they are not eligible for this benefit. The pigeon holes are very defined and limited, thus limiting coverage available for an older person.

(3) The Cost report is a nightmare. The cost report is burdensome and actually inflates cost. If you will look at the Federal cost report as required for a skilled nursing facility, the pages number over 45 pages. The whole financial reporting system should be revamped so that it is simple, clear, and fair.

(4) The billing process through the intermediary is burdensome. Complicated forms are used to transmit information.

Medicare program is a one-shot attempt to address health care needs of older persons. What is needed is an overall plan for long-term care for older persons in our society. A plan that includes a whole spectrum of services from those provided to the older person in their home to those provided to the older person who requires institutional care.

ITEM 4. STATEMENT OF JARRETT MOLEN, ROSE HILL, KS

The conservative Reagan-appointed Advisory Council has proposed significant increases in beneficiaries' out-of-pocket costs as a means of holding down medicare ex-

penditures. They made no recommendations on the cost controls for the overall health care system which should reduce medicare costs without cutting benefits. Costs of all segments of health care have risen for the past several years at three times the rate of inflation. It has consistently far outrun the increases in income the consumer has received to buy it with. We must have legislation to provide total health care cost containment. This is a must. There is presently pending legislation such as H.R. 4170. There's also a Senate version which would have frozen physicians' payments, but would not have cured the cancer by requiring mandatory assignment to prevent cost shifting to the elderly.

The Reagan administration attempted in 1983 to severely restrict hospice annual payments to $4,300. However, Congress adopted medicare part A which provides an annual payment of $6,500 opposed to Reagan's $4,300. This administration has again for fiscal year 1985 continued to push for less benefits for the consumer and requiring them to pay more for the medical coverage of those benefits.

Senator Robert Dole, Finance chairman, launched a planned tax increase and spending reduction of $150 billion, $14.1 billion was to come from medicare reduction from fiscal year 1984 to 1987, and also provided further cuts in the social security cost-of-living adjustments. Also provides that the age be increased for the recipient to qualify. The Congress and the President have all seemed to find money for the military, for missiles, mines, shells and bombs, etc.

We are presently in a dilemma over the President's approval for the CIA to direct covert activity in the planting of mines in Nicaraguan waters. Should this take priority over human needs? Sure, we need to protect ourselves militarily, but if we neglect the old, the young, the helpless and handicapped who need health care, what have we gained? Take a look at the countries who have been in war for years spending it all on war—nothing on the human needs; this we don't need.

I want to commend you Senator Kassebaum, for your having stood up and counted on the mining incident in Nicaragua, but it should be noted that your fellow Kansan, Senator Dole, wasn't there with you. And that, we don't like.

Now, let's talk about the means testing program. The proposed means testing is surely a farce. Both the employee and the employer paid into the system with all who were covered to have equal coverage in the medicare system. It was never intended to be a welfare program nor was it ever represented to be and surely should not be. If we can spend millions of tax dollars for Watergate and for investigating Reagan's cabinet members, then surely we can provide adequate medicare. There's been several members within the administration who have either left or been forced to leave because of wrongdoing. The latest case is that of Ed Meese who has violated moral law and probably the laws of this land. If I fail to meet my house payments for 7 months, as did Meese, I wouldn't have a house. If I had failed to report $15,000 in income to the IRS, I would have been expected to have been in jail. Several of his friends that helped him in his real estate sham. All have been given high paying jobs in the administration.

Let's take care of our elderly and our needy. They have helped build this country. It's been a great country. Let's keep it that way. What are we waiting for? Let's stop taking from the needy and giving to the greedy.

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